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PUBLIC HEALTH NURSING

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TWO 1950 CONFERENCES HIGHLIGHT CHILD CARE

THE YEAR 1950 brings two outstanding conferences. Nurses can give a great deal to both; they can also profit from them. The White House Conference on Children and Youth will meet in Washington in December. The International and Fourth American Congress of Obstetrics and Gynecology is meeting this month in New York. Both meetings will mark a time for thinking deeply about nursing in the second half of this twentieth century.

How can the Midcentury White House Conference stimulate us to increase the tempo of accomplishment for the well-being of children? That question calls for a look at the theme of this fifth meeting of the series of White House Conferences that began in 1909. The 1950 conference "bases its concern for children on the primacy of spiritual values, democratic practice, and the dignity and worth of every individual. Accordingly, its purpose is to consider how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship, and what physical, economic, and social conditions are deemed necessary to this development."

The Midcentury White House Conference is actually going on already, in its fact-finding phase. Governors have appointed state and territorial committees that, in turn, are organizing local committees in counties, cities, and towns. These committees are studying and discussing the theme of the conference, and looking searchingly at their services for children. How well are they functioning? What services are lacking? Are these services strong instruments for carrying out the purpose of the conference on the home ground?

National organizations whose work is for children are also taking part in these premeeting activities. They too are evaluating their programs in the light of the conference theme. They are asking themselves: "How deeply is our work affecting children? Are we helping them to develop soundly, stage by stage, through a healthful childhood—healthful in more than the physical sense—into a spiritually, mentally, and emotionally stable adulthood?" These organizations are starting projects and studies that will enable them to answer these questions at least in part.

When the conference opens in December these reports on local services and nationwide programs for children will be placed side by side with findings of technical research workers who are now busy gathering facts. From this network of fact-finding efforts spreading out over the country the conference will draw its recommendations. This many-

sided search for information that shows what is actually happening to children in this country may by its very process turn our thoughts and hopes about children into realities.

Nursing, like other professions, is taking its part in gauging the strength of local services and of national programs for children. Nurses are particularly active in one of the efforts to achieve the purpose of the conference—that is, to "study the ways in which the home, the school, the church, the law, health and social agencies, and other social institutions, individually and cooperatively, are serving the needs of children."

This local and national analysis may emphasize for nursing agencies one aspect of their own educational problem: How can nurses learn about child development? How can they become sensitive to practices and conditions that promote sound emotional growth? How can they learn to apply this knowledge, when gained, to their daily nursing tasks?

Educational opportunities, informal as well as formal, should be supplied country-wide, nursing agencies know. Institutes, workshops, or courses for nurses on the job, are greatly needed away from the centers of nursing education. Patterns for the different kinds of courses may be worked out in the centers but should be widely distributed for use elsewhere.

A nurse is very close to children when she is helping to keep them well and when she cares for them when they are sick. She is usually closer to them than the other professional workers who serve them. How well a nurse knows about her share in creating a healthful atmosphere around the boys and girls she works with is terribly important to their emotional growth. It will have a lot to do with how stably they grow in an all-round way.

The International Congress of Obstetrics and Gynecology is also a notable event. Nurses took part in planning the program and will take part jointly with the medical group in the meetings. Such joint action will once again emphasize the value of physicians and nurses planning together for the better care of mothers and children.

The program of the Congress of Obstetrics and Gynecology has much for nurses in its technical and scientific discussions. It will give them opportunities to learn how maternity care is provided in other countries. Some of the meetings will consider, for example, the nurse's part in service to mothers in natural childbirth, in rooming-in, and in efforts to make clear the relation between obstetrics and pediatrics. One session is on the social and economic aspects of maternity care.

Indeed, the Congress can do more than give us technical and scientific information. It can help us to think *internationally* as well as nationally about what we do. That is the way we *must* learn to think for the sake of mothers and fathers and children everywhere. Let us remember that what happens to *all* children is important to our own children, too. Because these other boys and girls, wherever they are, in Europe, Asia, Africa, or America, will grow into adults with whom our children as adults will live and do business, and we hope, wage peace and build a strong United Nations.

—Leona Baumgartner, M.D., *associate chief, Children's Bureau, F.S.A.*

NATIONAL HEARING WEEK

The second week in May is National Hearing Week. The American Hearing Society, which sponsors the week, is dedicated to the conservation of hearing, the prevention of deafness, and the rehabilitation of the hard of hearing. Through nationwide publicity during this special week, it is hoped the general public will be awakened to a better understanding of the hearing problem. About one person in ten has impaired hearing. Write to the AHS in Washington, D. C. for information and educational materials.

MENTAL HEALTH IN NURSING

ROBERT T. HEWITT, M.D.

TOTAL HEALTH has been defined as a state of physical, emotional, and social well-being. Today I am going to confine myself to a discussion of the emotional well-being of the individual. The principal reason why it is difficult to define what we mean by mental health is that in the field of mental health we are dealing with people's feelings, or if you prefer, emotions. It is not easy to describe our feelings with words. Quite frequently, we can tell from observation of a person how she feels about something better than we can from her words. We express our feelings through our facial expressions, our gestures, as well as through words.

On the other hand, we have trained ourselves so that we can conceal our feelings quite well when it seems desirable. Even though we cover up our feelings as carefully as we can, they still influence our behavior a great deal. It is unusual to associate with other persons for any length of time without their becoming aware of how we really feel about them. It is more difficult to conceal our feelings from children than it is from adults. It seems as we grow older that we are not so observant. Young children do not understand language very well and so are hypersensitive to the way people feel, just as a blind person seems to develop a greater keenness of other senses, such as hearing, than the person who is not blind.

Children give direct evidence of how they feel. Adults, on the other hand, must learn to control their feelings to some extent, or they would soon lose all their friends and their jobs. Even though we don't say just what we feel about each other, our feelings do find expression in many ways and every once in a while we do give real expression to them. But for civilized living, our hostile feelings must be pretty well controlled. When our most destructive emotions find expression, as they do in the mentally ill person, it is frightening. We have to pay a certain price for keeping our feelings under control. Hatred, fear, and jealousy can, when rigidly controlled, result in headaches, uncomfortable feelings in the abdomen, loss of appetite, et cetera. At times we get so loaded down that we must let off the pressure by some means. Some do it in a hurry with a fit of temper. Others do it in more socially acceptable ways through sports, hobbies, and other activities which they enjoy. Perhaps the most satisfying way is to talk it out with a friendly, understanding person who doesn't blame or moralize.

Feelings are very valuable things to the individual and to society in general. Every idea which we express has a certain amount of feeling of one kind or another connected with it. This feeling gives the idea its force. It might be likened to the powder exploding behind a bullet or the gasoline exploding in a car. It is the thing which keeps us going. The success of an idea or a project depends to a great extent on how strong the feeling connected with it is. In wartime, men must be aroused by fear and hate before they can go out and kill. A nurse must have a real feeling for people if she is to be happy and successful in her job. A mother must love her children if they are to be secure enough to grow into maturity ready and able to take on the problems of adulthood. Nor is the feeling always one which is considered socially desirable. A short time ago the newspapers

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published a report of a man who killed his wife and children and then attempted suicide. He said that he did it to save them from starvation, but they were in no danger of starvation. The real reason lay somewhere in the realm of his emotions. He did not know himself why he did it. This man, of course, was mentally ill. How much different, except in degree, is the person who indulges in unnecessary criticism of another without realizing why he does so?

WE ALL HAVE EMOTIONAL NEEDS which must be satisfied if we are to live happy and useful lives. The most important period in life, so far as the development of personality is concerned, is that of early childhood. Children have certain emotional needs which are easier to discuss than the emotional needs of the adult because children are less complicated than adults. The emotional needs of children are satisfied principally by parents, or persons representing parents. Later on, in addition to the parents, there are relatives, companions, teachers, and others. The child needs first a warm, permissive, affectionate environment from which he gets security and a sense of belonging. While in this environment, he continually develops independence. It is necessary that he be able to explore and learn, as a child says, "do it myself." This beginning independence is the earliest manifestation that the child eventually is going to grow up and have to depend on himself. If he is held so close in the protective relationship that he is not allowed to develop independence, he will tend to grow into a dependent person who is unable to stand on his own two feet. On the other hand, if he does not have the secure relationship of an accepting home he will be insecure in later life; he will be fearful of entering into relationships with other people; and he will have difficulty in making decisions. He will always question that anyone can really love him, and though he will seek affection, he is likely to respond with suspicion and doubt when it is offered.

Emotional needs have not been satisfied equally in all of us, and consequently we are not all the same kind of adults. We go on seeking the things we have not received in childhood. In childhood we sought them from our parents and those who represented parents; and as we grow older we seek them from people who take the place of parents in our lives. There are few who do not need the help of personal relationships of an affectionate nature to survive. Some of us are more dependent on these relationships than others.

There is a wide range of normal in this regard. Some people are able to give much to others. It seems that their storehouse of affection and understanding is full and is never depleted. Such people are found in every group. They are understanding of others; their feelings are not easily hurt; and people go to them for help and counsel. At the other extreme, there are those who have had very little affection and security in childhood, and their wells of affection and understanding are almost dry. Their emotional needs are great and in the emotional relationship they are like leeches. They suck the relationship dry and give nothing in return. Such a person is unhappy. We don't like her very well. Few people are willing to continue giving to such a person in a friendship with no return; consequently, she has few friends. We say that she is unlovable, and the sad part of it is that she knows it and is a very unhappy person. Because she didn't get affection in childhood, she turned on her parents with hostility. She carries that attitude into adulthood, and so feels hate for the persons from whom she wants love and understanding. This, she also knows and is unhappy about. We say that she is hard to get along with.

If such a situation is discovered in early childhood we can help the parents or find a foster home for the child where the foster mother has deep wells of affection. In adulthood this extreme personality has a difficult time adjusting and often needs special psychiatric help. However, a great many such people manage to keep on working if they have the help of sympathetic colleagues and supervisors who give them reassurance which they need almost constantly. These people go through periods when their symptoms are

much worse than they are at other times, and they can be helped along through sympathetic understanding and may be kept on the employable list rather than becoming problems to society in general.

Most of us fall in between these two extremes. We have unmet emotional needs, but we also have some capacity to give to others. We need recognition of our work. We need some human relationship. We need to feel that we are wanted and appreciated. For example, we are willing in varying degrees to submit to supervision, but in return we expect appreciation and recognition of our work as individuals. We need to feel independent, and our best efforts are brought forth if we are allowed to help in the planning of the work to a certain degree. Then we feel that we are not just doing a job, but that we are part of a group which is striving toward a common goal.

THERE IS ANOTHER relationship which is productive of some difficulty, and here I must be careful because I am directly concerned. I speak now of the role of the special consultant in any phase of health. This role is one of the most difficult to fill adequately. We learn the hard way. We frequently go into an area or organization and find things not to our liking. We have some preconceived idea of the way things should be run; we tell the people in the area what is wrong with the way they are doing things; and we make recommendations for improvement. They do nothing about the recommendations and never ask us to come back. Why? The recommendations we make are founded on the experiences of others and on our own experiences. There is nothing essentially wrong with them. We have acted in good faith, we think.

There have been thousands of surveys made of state hospitals, welfare agencies, health departments, and other agencies which are gathering dust on shelves. What do feelings have to do with all this? In the first place, most of the agencies surveyed know that they have deficiencies. They often know only too well what they are. They also know their needs, and they would like to have help. But they are sensitive, and they need recognition and understanding. People do not like free advice. It places them in a humiliating position, and makes them feel that they have failed. This, they can't accept, and so they reject all recommendations, whether good or bad. They also reject the individual who has aroused this feeling in them. What do they want? They need to be recognized as individuals who all too often are working under many disadvantages. They want to be given credit for what they have done. They want us to get to know them, and they want to get to know us. We must give understanding and sympathy, and help them to work out their own problems themselves. In other words, we must first satisfy their emotional needs, and then they will be more ready to accept our help.

Listening to people should be one of the easiest, but actually is one of the most difficult things to do. The need to impress our own ideas and methods on others is great. Allowing people to talk enables them not only to let us know how they feel, but also gives them an opportunity to get rid of a great deal of feeling which bothers them. By listening to people we get to know them and much more can be accomplished if there is an understanding between people. In our roles as consultants or supervisors, we usually have something definite which we want to accomplish. The people we are working with also wish to accomplish the same objective. However, we all work best by our own methods. Better results can usually be obtained if through discussion we can determine what we want to achieve, then give the individual some latitude in the method by which he achieves it. In this way you get the full benefit of the abilities of your staff, as they will be more interested in what they are doing and will not feel tied down by nagging details and too much authority.

IN ANY ENTERPRISE where cooperation is required much the same holds true. We must all be able to give as much or more than we take out of the relationship, and the person who is the supervisor or the consultant, or in any way in the dominant position, must

be able to give the most to get the best from the efforts of others. It is one of the essential qualities of good leadership.

There are some things, which if understood, make leadership less difficult. I mentioned the hostile person who takes, but gives very little. These people periodically "let off steam." The supervisor is often the recipient of a large part of this. It is hard to take. The hostile person lets off steam usually after what she considers to be the last straw in a series of insults which to others appear insignificant or fanciful, but which to that person are nonetheless real. Or, she may go on sniping at her supervisor over a long period of time. That is also hard to take, but she needs to do this. Her emotional needs are so great that she can't function unless she lets off steam. Such an individual will continue to behave this way toward persons in authority. The supervisor must realize she is only a symbol of authority, and the revolt is against authority in general rather than against any individual. If the unhappy person is given an opportunity to talk it out, she will discover this for herself and will usually become much more cooperative.

The factors which have been discussed are no less important in the nurse-patient relationship and in relationships between colleagues. Understanding of people's needs goes a long way toward helping them. You all know better than I from your own experiences how important the role of the nurse is in working with patients. Patients coming into a hospital have the same emotional needs as others, only more so. The situation is strange. They are afraid, and fear provokes irritability or other unusual emotional reactions. Sometimes, we, as doctors and nurses, satisfy our own need for being important at the expense of the patient. The traditional role of the nurse is in keeping with mental health practice. She necessarily satisfies some of the emotional needs of the patient, and certainly none would underestimate the importance of feeling and attitude in the progress of a patient toward health.

The treatment of the mentally ill is a field too large and specialized to be included in this discussion. But in helping to meet the emotional needs of the mentally normal but physically ill patient the nurse has a job to do. It is impossible to be just physically ill. Emotions are always affected, and people who are quite competent in everyday life become quite different when ill. We are so organized that we can control our emotions fairly well when we have no unusual stresses, but under the added strain of illness we are not so successful. The doubts, the fears, and uncertainties which arise upset our controls. Some people slip back a little toward childhood, and their emotional needs are those of children. The nurse becomes the mother who understands and reassures. Some people accept illness and have a hard time giving it up. They have always had a hard time developing independence, and when they have the opportunity to be taken care of again have a tendency toward invalidism and must be stimulated and pushed.

In any case, no matter what the emotional reaction, the nurse is always an important figure in the emotional life of the sick person, and as such is vitally important in the recovery of the patient. How well the nurse is able to satisfy the emotional needs of the patient often determines how soon he will be able to be on his own again. When ill he surrenders himself emotionally and physically to the nurse and physician. We must give him the emotional support he needs, but at the same time keep him from becoming too dependent. He must be able to keep his self-respect and self-confidence. This is brought out well in early mobilization of patients after surgery and in obstetrics. They don't have time to get too dependent and are much sooner on the road to recovery.

THERE ARE interesting experiences in this regard in a college infirmary. Many students are away from home for the first time. They can't go to their parents for the emotional support to which they are accustomed. They frequently end up in the college infirmary with symptoms of some nature. They are kept overnight perhaps, or are just seen as outpatients. Often no diagnosis can be made. What do they want? They want their emotional needs satisfied. They want, let's say, "a little

loving" in the form of individual attention. As they progress through college, they will develop more independence; they will grow up; and they won't need this as much. They will find other human relationships from which to get satisfaction. The nurse here, as in countless other instances, is playing mother to them. She gives them reassurance, understanding, and support. She is practicing mental health.

At the Mental Health Center in Phoenix, Arizona, we are more concerned with the parent-child relationship than with any other phase of mental health. As I mentioned previously, successful meeting of emotional needs in childhood is essential if the child is to develop into a productive, happy adult. For this reason we say that we are working in the field of prevention. A more positive way to look at it is that we are helping parents and children to realize the enjoyment and real happiness of a growing family relationship.

If parents think in terms of problems in child growth and development they tend to go around with furrowed brows and guilty consciences, wondering if they are doing wrong. If they can think of their children as developing people who will behave differently at different ages, they will find pleasure and interest in the process. Parents whose emotional needs were satisfied in childhood do enjoy their children because they enjoy giving. Parents whose emotional needs have not been satisfied in childhood will have more difficulty enjoying their children because they cannot give as much but must take from the relationship. These parents need help. They need someone they can talk to about their feelings. Their children are a bother to them because they want attention, usually when the parents want most to do something for their own amusement. The child-parent relationship is strained and the child suffers.

If we are to help parents realize the satisfaction and pleasure there are in having children and living with them, we must start before the child is born. The nurse plays a very important part here. A woman about to have her first baby usually has some type of antepartal care. The physical care is vital to the future of the mother and child. But isn't there something else which the woman wants? What about her feelings? Is she worried, afraid, and apprehensive? Is she the victim of all her neighbors and grandmothers who fill her full of old wives' tales and tell her in detail of their pains and difficulties in labor? She will get information from some source, so why not make it real and helpful? She needs an opportunity to talk to some sympathetic, understanding person who has had sufficient professional training so that she not only can listen, but also can give support and reassurance. Here the nurse has an advantage because the traditional role of nurse is that of helping other people. She is accepted in that role.

YOU HAVE NO DOUBT HEARD of the efforts being made to prepare women so they will not have much pain in labor. Last summer I visited a doctor in Detroit who is working on this phase of maternal care. He believes that fear has a great deal to do with the tightening up of muscles and severe pain when they are stretched. He attempts to relieve fear through explanation and reassurance during the antepartal period. His nurse assured me that these women are more comfortable and usually do not need medication or anesthesia until the third stage of labor.

We all want to be relieved of a situation which arouses fear, so it seems that if an expectant mother is less fearful, she will be more receptive to the pregnancy and will not carry over a rejecting feeling toward the child after birth. Eventually the expectant mother will enter the hospital. She delivers the baby and is back in bed. Now again she is thrust into a new situation. She has a baby which she doesn't know how to care for. She is anxious and wants to do what is right for the child. It would seem that now, while she is in the hospital with nurses around who know how to care for babies, would be a good time for her to get used to handling the baby and caring for him. If the baby is kept from her except at feeding time, she will never get to know him. The baby will be given to her on the day she goes home. She will worry when he cries and be afraid to handle him for fear she will drop

or hurt him. Her fear again will tend to arouse dislike for the baby who is the source of her fear. The mother-child relationship, which is so vitally important if the emotional needs of the baby are to be satisfied, does not develop into a very happy one under such circumstances.

A NEWBORN CHILD is not a thinking person. He is a feeling person. All his needs are satisfied by things which arouse pleasant feelings. Feeding, elimination, sleep, warmth, and physical comfort are important. However, in orphanages where these needs are met with a minimum of handling and individual attention because of lack of time, we find that the infants and young children are listless, develop more slowly, and lack emotional warmth. If the emotional needs are to be met in this feeling individual, the infant, there is something of more importance than impersonal routine. Just as it is important for the child to have an adequate formula, so is it important that the mother supply emotional warmth by a close physical relationship with the infant whose emotional needs are supplied only through feeling. The more physical separation there is between mother and child, the more weakening there is of the emotional tie in early infancy. The more familiar the mother becomes with the behavior of normal infants, the less anxiety and fear she will have, and consequently the more she will enjoy her child.

Maternal affection is an emotion which comes from within and cannot be taught by books. However, it can be helped along. With a sound basis in early childhood we can be fairly sure that the emotional needs of later childhood will be met as they arise because the right feeling exists in the relationship. Many of the real tragedies we see in clinics where so-called behavior problem children are brought for help are a result of anxiety-ridden parents who are afraid to act naturally with their children because they think that child-raising is a complicated and dangerous process. Because of their fears and doubts they cannot feel naturally about the child, but attempt to "raise him by the book" in a cold and affectionless atmosphere, not because they don't want to do the best they can for the child, but because they don't know how.

The public health nurse in the well-baby clinic and in her visits to homes where there are children, especially where there is a first baby, has an opportunity to help the mother get used to her baby and to feel comfortable with the baby. She is accepted as a welcome visitor because she helps people. She will be aware of the mother's anxiety about her baby. In discussing feeding she can desensitize the mother with regard to worries about normal behavior in the baby which appear abnormal to the mother. For example, if the baby refuses to drink the entire bottle at one meal the mother may worry a great deal. But the nurse, in discussing feeding, can casually mention that this often happens, and the baby will make up for it at a later feeding. The nurse may do the same with regard to toilet training, sleep, and other things of that nature. She can help the mother to keep from feeling guilty about many things by assisting her in realizing that there is not one exact way of doing things. We are all different, and the important thing is to feel comfortable. If the mother feels comfortable about the situation she feels more adequate and enjoys the child. As pointed out earlier, children are very sensitive to adults' feeling toward them. It is hard to fool children, and we can't go through the motions mechanically and satisfy them. Affection must be real to satisfy the child's needs.

I HAVE PURPOSELY left out a discussion of the problems and the abnormal. There will no doubt always be a place for treatment clinics and mental hospitals, but I think that sometimes we forget the great mass of the population which is going along doing the everyday work of the world and maintaining sufficient emotional stability to be productive. We, as nurses and doctors, sometimes get so involved in the sick that we forget to look on the positive side, which is that of the preventive field. In doing this we tend to think of the normal ordinary problems of

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Maternity Care---2000 A.D.

MARGARET W. THOMAS, R.N.

THIS IS NO ATTEMPT to join the league of philosophers and scientists who unhesitatingly make profound prophecies for the future based on studied analyses of social change and computations arrived at by peering at intricate machines. In fact, not even such unscientific equipment as a bag of fancy tricks or a crystal ball is needed to foresee that some of our hopes for maternity care today may come to pass by the year 2000 A.D. But if we are to see progress as we look ahead we must first stop and take stock of where we are now in thought and action.

There was a time in obstetric history (and this within the past 50 years) when home delivery was the accepted thing. For the last 15 or 20 years, emphasis has been placed on encouraging mothers to go to the hospital for delivery. And a good job has been done in this respect, at least as far as mere numbers are concerned. In urban areas in 1940, for example, 76 percent of all women delivered in hospitals, whereas in 1947 the number increased to 93.8 percent. In rural areas in 1940 only 32.3 percent of deliveries occurred in hospitals, while in 1947 the figure was 71.3 percent.* Having accomplished this, can we not now hold the line and, at the same time, move on to a different emphasis? You protest, "But we have!" Let me cite an experience I had a short while ago which seems to indicate that some nurses, at least, are still thinking of maternity care of a scope limited to about this level.

Are you familiar with the free association psychological tests in which the testee is requested to look at a picture or listen to a word or phrase and say what the picture or words first bring to mind? Recently, I gave a pseudo free association test to a group of nursing students at a university. The stimulus words were *maternity care*. It was my hope to get answers of ample variety to demonstrate that maternity care is as broad as a generalized health program and, in fact, even broader, reaching as it should to many community services other than those of agencies and institutions whose major concern is with physical health. Typical of the answers received are the following:

Labor	Rh factor
Doctor	Maternity clinic
Delivery room	Babies crying
Perineal care	Maternity cycle

Granted that the majority of these nurses were fresh from the four walls of hospitals where much of their thinking was directed to the serious day-by-day business of routines of patient care, and that the idea was to express the *first* thought that came to mind, it still seems that more of the answers might have indicated that maternity care means something to nurses other than women in hospitals and in labor.

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* Federal Security Agency, U. S. Children's Bureau. Adapted from *1947 chart book—infant, and childhood mortality, maternal mortality, natality*. p. 31.

WE ARE CONCERNED, and have been for many years, with "the entire maternity cycle." Public health nurses have been admonished to see that pregnant women seek medical care by the third month of pregnancy. No way has been devised to determine progress in this campaign, but from 170 agencies reporting these data for the health practice indices† we learn that only about 63 percent of women are under medical supervision before the *sixth* month of pregnancy. It seems unnecessary here to point out the *why* of this emphasis. Suffice it to suggest that in this one elementary area there is much to be accomplished in the next 50 years.

Have you stopped to consider how many hazards associated with childbearing could be prevented simply by promoting the best possible health programs known to us today? A prospective mother is told by her physician that she must have a caesarean section because of pelvic dystocia. Could that condition date back to rickets in childhood that might not have existed if she had been under medical supervision and her mother had understood the significance of proper nutrition? A pregnant woman's life is in danger because of a seriously damaged heart. Need the damage have been so severe if an adequate regime of care had been established and followed when she was found to have rheumatic fever in childhood? A young woman, who very much wants a family, has been unable to carry a pregnancy beyond the sixth month. Is this because she has syphilis which has been unrecognized and untreated?

So far mention has been made only of factors relating to the physical care of mothers-to-be. But a mother is more than merely a well oiled machine, expected to function on all cylinders and without knocking. She is more than a biological organism—she is biosocial. In more recent years there is a trend, at long last, to give some emphasis to the social being. A mother is beginning to be recognized as a person with a home, a husband, and perhaps other children, as well as one with a uterus, breasts, and labor pains. Although mothers' classes have been held here and there throughout the country, for at least a quarter of a century, we are just now beginning to accept broadly the fact that those who attend these classes are as much interested in how the baby develops within them, how they, personally, can assist the natural forces of labor, and how best to adjust the new baby to the home situation, as they are in what kind of shoes a pregnant woman should wear and what percent of wool the baby's shirt should contain. And we are beginning to see the father as more than the person who brings home the canned milk and is called upon to cope with the disciplinary problems that are too strenuous for mother's right arm.

Voice is being given now to a fact long known—that all parents do not want and dearly cherish their children. But at the same time, attempts are being made to study the cause and effect of early relationships that may have resulted in such rejections. In truth, the potentialities in the area of mental health in maternity care are so vast that they hold for the future a reservoir of experimentation and activity of unsoundable depths.

HAVING REVIEWED BRIEFLY the state of affairs in maternity care at the beginning of 1950, let us look ahead a half-century. Whether I am accused of fantasy or daydreaming makes little difference, since in the year 2000 A.D. I will not have to face the shame of any false predictions.

Before speaking of community services, we might ask: What of the preconceptional care of the typical young couple who will be seeking guidance when a new baby is on the way?

They have been under continuous medical supervision since infancy—the kind of supervision that recognized the definition of health put forth by the World Health Organization: "Health means a state of physical and mental well-being, not merely the absence of disease or infirmity." They have been members of families where love and "wanting" have existed, and have learned from this home life that marriage and the rearing of a family can be a joy. They have had the kind of parents who gave them without shame scientific an-

† Committee on Administrative Practice of the American Public Health Association. *Health practices indices, 1943-1946,* p. 31.

swers to their questions concerning mating and social relationships. The schools they attended cooperated with their parents to enlarge their knowledge of interpersonal relationships, and promoted a wholesome intermingling of the sexes.

Through courses at the secondary education level, through the pastor of their church, and through a marriage counseling service, they have learned much that will enable them to get along as well as possible, within the limits of their spiritual, emotional, and economic capacities, as husband and wife. As a final check, they both have had complete and thorough physical examinations just prior to marriage. Chest x-rays and blood surgery were negative, there were no physical incompatibilities (Rh factors were determined years ago) and there was every reason to believe that pregnancy was possible. Now they eagerly look forward to the new experience of being parents.

As for the care she will have available during 2000 A.D., the young mother-to-be will have the benefit of all that medical science knows that will make pregnancy and the birth of her child as safe and emotionally satisfying as possible. She will not have to be deprived of needed x-ray pelvimetry or other expensive tests because of unfortunate financial circumstances. Her physician will know that she may be referred for these services as indicated.

By 2000 A.D. the practicing physician will have learned that the public health departments and other community agencies are resources he can use to reinforce his treatment, and are in no sense competition. He will not be concerned if these young people, perhaps because they are strangers in town, went first to the health department for guidance in finding a physician. Referrals between community health agencies and practicing physicians will be made freely in both directions. The physician will know that his instructions will be carefully interpreted by the public health nurse, that recommended treatments will be conscientiously carried out, and that reports will be made to him of tests he wants done or of findings resulting from a home visit.

In the health department, which will be a part of the community health and hospital center, there will be more staff ready to serve our young couple than the lone public health nurse who now must try to serve all people in all things. The number and kinds of professional workers on the health department staff will be dependent on the size and the needs of the community. The basic professional staff of health officer, public health nurses, and sanitarians, will be trained in public health and will draw to the ultimate on other community resources to meet the needs of expectant parents. And there will be adequate clerical and other auxiliary assistance to leave the professional personnel free to concentrate on professional things.

THE YOUNG COUPLE WILL BE encouraged by their physician to attend the parents' classes. Every one will realize that there is no time like that during pregnancy to impress on the parents certain facts relative to the care of the mother and the birth and care of the new infant. As a result of attending these classes, and knowledge gained from other professional contacts, the mother will face confinement with the minimum of fear and tension, and delivery will simulate more nearly what is now popularly called natural childbirth.

If the young couple is worried about plans for the mother and infant to return home these may be discussed with the health department's medical social worker. If there is no maiden Aunt Susie to come to the rescue, or if the husband's mother would turn the household into an uproar, there will be a varied assortment of household helpers to be called upon, depending on the need in the home.

The hospital in which the new baby will draw its first breath will be no mysterious structure on the hill. As a result of attending parents' classes, which included a visit to the hospital, the workings—at least of the obstetric department—will be familiar to the father- and mother-to-be. In 50 years the public will know the necessary components of a safe hospital and will realize that a well-equipped and well-run hospital is just as es-

sential to good maternity care as adequate medical supervision.

When the husband goes to the hospital with his wife, when labor begins, the two will find there an atmosphere of homely friendliness. There will be more staff in hospitals, too, in this bright future, and nurses and doctors alike will have more time to accept patients as individuals and to spend as much time with a woman in labor as her peace of mind and safety of body require. The cold, shiny statue of professional efficiency will have become a little tarnished by the human touch. Hospital administrators will have learned personalized service results in happier public relations. Whether rooming-in will cost more in terms of medical and nursing time no longer will be argued. Rather it will be said, rooming-in is a valuable experience for some mothers; we have provided for it here.

Although our young mother's physician may not be on hand to greet her, the personnel in the hospital will be in a position to render care until he arrives. Not only will they have had telephoned instructions from the physician, but they will have a series of reports from the physician's office (or maternity clinic) and from the public health personnel who have been cooperating in giving care during the antepartal period.

The role of the nurse in the hospital as an educator will have become more completely manifest, and teaching mothers and fathers the care of the new baby will be accepted practice. This teaching will be correlated with that done by the nurses in the community, to avoid duplication and overlapping and to assure that the methods taught in the hospital are adaptable to the home.

If the pendulum has not reversed its present swing toward early ambulation father will be taking mother and baby home from the hospital in three to five days, provided things have gone well. If, however, the physician feels that closer surveillance is needed than might be available at home the mother and infant may be transferred to a convalescent unit of the hospital where a transitional type of care may be given. In 2000 A.D. the financial status of our young family will never be a barrier to their getting any of these medical and hospital services.

Prior to discharge from the hospital the physician will order referral to the community nursing service. All referrals will be gladly accepted because there will be sufficient nurses to handle them. These referrals will include not only a report of the physical event of delivery, but a summary of the parents' adjustment to the new baby and a résumé of their learning experiences. The nurse in the community, then, will have time to visit each home as seems indicated to give what help she can to the new family unit. She will understand that there might well be some "hitch" between what the parents learn in the hospital and their ability to put it into practice.

By 2000 A.D. there will no longer be conflict over where maternity care ends and child care begins. As the nurse starts to relax contentedly over the fact that the new mother has had a postpartal examination and an evaluation of her condition in relation to future childbearing, she will realize that this is not the end of the line. Here is a new human being—a new potential parent—and the cycle begins all over again!

Many who have read this far will recognize that there is nothing really new in what is predicted for the future. The newness lies in a greater acceptance of the fact that maternity care is as broad in scope as good health and happy family life and, finally, in achieving by 2000 A.D. the goals that are recognized as desirable in 1950.

THE VISITING NURSE VIEWS ROOMING-IN

ELAINE BAUMANN, R.N.

STAFF NURSES OF THE New Haven Visiting Nurse Association, whose privilege it has been to work with "graduates" of the New Haven Hospital rooming-in project* in the three years since its inception, have been observing with keen interest a hospital program which focuses upon the *family*. Pooling our observations we find that approval of the plan among those who have tried it is almost unanimously enthusiastic; New Haven likes rooming-in.

Nurses of long experience compare the plan favorably with maternity care in the home. Familiar surroundings at home, the solicitude of the immediate family, and the attention of doctor and nurse to mother and baby as a unit offered advantages which the hospital's efficient care of large numbers of patients seemed to prohibit. It is the general impression of the VNA staff that rooming-in is succeeding in bringing into the hospital many advantages of home care. Add to this the advantages of modern obstetrical practice and equipment, and much careful "listening" and teaching by the professional staff, and we have something unique in mother and baby care.

Our impressions of the value of rooming-in are particularly vivid on the first home postpartal visit to a rooming-in mother. This is considerably different from the usual "first-day-home" visit. The latter is often a near emergency, as every staff or student nurse of even brief experience in the field will agree. The peace of mind wrought by close association of mother and baby in the hospital, and the sharing of this experience with the father, seem to permit more couples to carry home with their infant the joy and satisfaction with which this occasion has been anticipated. It is sad to note how often these normal reactions have been dispelled by the fears arising from ignorance and lack of confidence of the parents in their ability to care for their own child.

A superhuman job is sometimes asked of the visiting nurse, who is expected to teach a new mother "all she needs to know" about the care of her infant on a first home visit. Mothers' classes and antepartal home visiting are known to help a great deal, but the actual presence of the infant in the home is sometimes seen to bring about an apparent personality change in the mother. In some instances the pain and anxiety of those first days at home with a first-born baby may not be overcome for many weeks, and may strongly influence the mother's attitude toward subsequent pregnancy.

The girl who tells us that she is "not afraid to give birth to the baby but is dreadfully afraid to bathe him," is an excellent candidate for rooming-in. There she finds reassurance in her increasing ability to care for her infant. She is offered an opportunity to know him well, and is helped to assume gracefully her

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* Rooming-in is described as "the hospital arrangement whereby a mother may have her newborn baby in a crib by her bedside whenever she wishes," according to Edith B. Jackson and collaborators in their paper, "A hospital rooming-in unit for four newborn infants and their mothers." *Pediatrics*, January 1948.

new role of motherhood. Her baby is just a little different from every other baby in the world. Her knowledge of these differences, plus a practical understanding of the ways in which his manners are those of all infancy, free her to enjoy him when she takes him home. We see it happen.

One mother of three tells us that her present success in breast-feeding is due to the help she received in rooming-in, but more particularly to the fact that she had the baby with her, where she could observe his needs and answer them promptly. She is more than ordinarily positive in crediting rooming-in with this success because of two previous failures. Although she had tried equally hard to breast-feed each of the two other babies, she had left the hospital each time with a formula and bound breasts.

Testimonials of this character could fill many pages, and already do appear in many types of professional and popular literature. The absence of unfavorable comment in such publicity sometimes results in rather dubious reception by professional people. In a sincere attempt to disclose all varieties of reaction to rooming-in members of our staff have found relatively few adverse or unenthusiastic reports. Some mothers have complained that rooming-in started them "spoiling" their babies. This often seems to reflect a lack of understanding of demand feeding, upon which Dr. Jackson has written so lucidly in a recent article.†

Rooming-in for New Haven is "for those who wish it." Frequently mothers of large families have preferred to have the baby "filed away" in the nursery. To these mothers a rest in bed, with someone else looking after the baby, is a luxury not lightly to be dismissed. Of others who have not accepted the opportunity to try rooming-in, there are a number who do not understand what is meant by the term, and who, even after considerable explanation, are wary of something new. Some of these are younger women, who take their counsel from members of their family. Others are the mothers of several babies who did very well the "old" way. These people may feel otherwise about the rooming-in idea when they understand that it is the very *oldest* way, all dressed up in modern hospital technic and medical language.

MOTHERS WHO HAVE HAD previous obstetrical experience with which to contrast their rooming-in are by far the most enthusiastic about the plan. These mothers often assume almost missionary zeal in their eagerness to influence their friends and relatives to take advantage of facilities from which they feel they have gained so much. Since these are the women who say they "have already learned the hard way," it is less the educational and practical help offered by the plan for which they are so grateful. They value highly the emotional satisfaction of being with the baby those first few days, even though they would not otherwise have felt him to be a "little stranger."

Actually, it is rarely or never that we hear mothers complain that their sleep is broken by the presence of the four infants in the unit. Since this is the criticism which had been much anticipated, we looked about for an explanation. Some of the younger mothers tell us that they "never heard anyone else's baby." One girl said she was so much a "lioness all wrapped up in her cub" that what the rest of the world did just didn't matter to her. Mothers who had previously had babies who were kept in the nursery said that they were able to sleep in the hospital for the first time, when they were admitted to rooming-in. They explained that a mother who hears a crying nursery baby always identifies it as her own. This keeps her in constant anguish, which is relieved by permitting the baby to remain where the mother can minister to his needs, keeping him relatively quiet, and allowing her to relax.

Several expectant mothers have been referred to rooming-in after calling the VNA to inquire about "baby nurses." In one such instance the expectant parents were very anxious to make specific arrangements for domestic help, which they could ill afford, months before the baby was actually expected. They were accustomed to arranging their af-

† Jackson, Edith B. Do you really understand the demand schedule? *Baby Talk,* January 1950.

fairs in an efficient manner, and since the care of a newborn infant was outside the scope of the rather broad education of both husband and wife, they felt it was something for someone with "that type of experience" to handle.

In making the first visit in response to this call the nurse answered the young woman's questions about sources of domestic help and baby nurses, and about the services of her own visiting nurse association. As she watched all this information being systematically written down the nurse made a little private bet that these references would never be needed if the young woman could be convinced of the value of available antepartal instruction, and could have the help of rooming-in at New Haven Hospital, where she was planning to deliver her baby.

From this point the visit developed into a discussion of the educational possibilities of the experiences of childbirth and child-rearing. Good-naturedly, the mother-to-be was able to see that her efficient and utilitarian approach to her "problem" might more fruitfully become a wholehearted acceptance of her pregnancy, with all the exciting implications of bringing a new human being into the world.

She subsequently received much assistance from reading accounts of rooming-in experiences as they appeared in popular magazines. Her obstetrician gave his consent to her participation in the program of antepartal instruction at New Haven Hospital, where it was arranged that she should have her baby with her after delivery. She attended an entire series of VNA mothers' classes, and was a most interested and apt pupil.

ALL OF THIS TEACHING, plus the services of a fine obstetrician, could not have completed the work of helping this young woman grow into her new and unanticipated motherhood. It took rooming-in to give her the actual practice which no amount of preliminary theory could have given. It was a long step for a patient who was afraid to touch a tiny baby to succeed in breast-feeding, but with constant, gentle guidance and patient instruction, she gained confidence and learned to enjoy a fundamental, simple experience, which she had planned to deny herself.

When her own mother came from out of town to help her over the first few days at home they were both able to enjoy the baby. The dreaded "period of adjustment" became a happy week for the whole family. The young father, who had not even wanted to admit the fact of the pregnancy at the time of the first nursing visit, was the first to take the nurse to the bassinet to demonstrate his skill in "picking the baby up," and to display his son. He had found considerable help in his talks with the pediatrician in the hospital.

Difficulties anticipated in relation to having the grandmother in the home ("mother makes us both nervous") seemed to be dispersed by the confidence which both parents had acquired in matters of diapers, ad lib schedule, and tender, loving care. Grandma could only stand back and admire.

Not all mothers come from rooming-in with uniform skill and equal enthusiasm for their new responsibilities, however. We cannot concur in general with the editor who captioned a mother and baby picture for an article on rooming-in with this statement: "She will have no fears when she goes home because she is already well acquainted with her baby." Though this may seem similar to what has been said earlier in this paper, we wish to qualify this optimism.

The nurse does not assume, in visiting the rooming-in mother, that she will be free of fears, regardless of her previous learning and experience. The cosy hospital unit, flanked by similar units with other mothers and babies, remains in apposition to the isolation of one's own home, especially when one has been surrounded by well-informed, capable medical and nursing personnel whose help is readily available. The visiting nurse steps into the gap left by the mother's separation from the competent staff which has given her so confident a start. The nurse becomes the liaison member of the professional team which is caring for mother and baby.

The fears and difficulties encountered in each home are as diverse as human personality. For example, we should point out that the mother whose experience has been cited at length was undoubtedly a rather exceptional person, who, through previous training,

was prepared to use the resources offered in order to succeed at an undertaking, much as she might have done in scholastic competition. Her gain was in direct ratio to her ability.

Since the rooming-in experience does simplify the teaching of the more obvious aspects of infant care, we find that the focus of the nursing visit moves much more rapidly to more subtle and sometimes more disturbing problems which might otherwise be obscured by attention to bath, clothes, and the mechanics of feeding. In the family just discussed the particular problem was one of reassuring the mother that she was not lacking in love for her infant because she had not wanted him from the beginning.

On the other hand, there are homes in which rooming-in experience does not appreciably reduce the necessity for teaching visits. The tense, apprehensive mother continues to be dependent upon her visiting nurse for many weeks. Certainly, we do not expect rooming-in to change such a person. However, the nurse making the first-morning-at home call to a mother whom she knows to be timorous and dependent knows also that the patient has had some instruction and reassurance if she has roomed-in with her baby. She at least knows what the baby looks like and has handled him. She has heard him snort, gurgle, and sigh through the night, has lived through several anxious episodes of hiccoughs, and has had a hand in his care. Even if she has not given him his care, she has gained by seeing him handled and hearing him cry when he was bathed. When we visit this mother we are grateful that the work has been so well begun.

THE MOTHER WHO HAS had rooming-in often seems to look to the visiting nurse for suggestions in applying what she has learned in the hospital to her home regimen. The nurse can be of particular help in aiding the family to understand that a "self-demanding" infant will gradually become less demanding as his capacity for nourishment grows, and the family learns to interpret his needs and fulfill them with ease and dispatch. We find that mothers who must meet conflicting advice and opinion look to us to verify and to reassert what has been taught in the hospital. In order to meet this responsibility the nurse must be aware of current recommendations of the pediatric staff. The rooming-in staff is readily reached for consultation, making it possible to clear up minor difficulties and to avert major crises in most cases with relative ease.

In the rooming-in program, the pediatrician is known to the mother, and frequently to the father, before the baby is born. The mother comes to know the pediatric staff well during her hospital stay, and she has at least one home visit from the pediatrician later. This close working relationship between the family and the medical and nursing personnel is one of the goals of the rooming-in program. Mothers and fathers have been particularly vocal in their praise of this aspect of the project.

Perhaps the true value of rooming-in for most mothers is illustrated by the experience of a mother who deferred to a younger woman in the ward, when given the opportunity of being transferred into a rooming-in unit. The younger girl had been highly emotional and excitably worried about her baby in the nursery. When the visiting nurse later asked why the mother had given up her chance of being admitted to rooming-in, she replied, "I really wanted my baby with me, but I didn't need all that help like that poor girl. Why, that rooming-in is just wonderful!"

She knew that rooming-in was wonderful because she had managed to do without it. The heartache of the new mother, who wants to be with her baby and is separated from him, might be a true measure for evaluating the rooming-in project.

Role Playing in Exploring Relationships

HUBERT S. COFFEY

WE ARE ALL interested in human welfare. Our separate specialties, though distinct in their method and scope, have one essential tie which binds, a sincere interest in promoting individual growth and community welfare. As specialists our particular approach and efforts are likely to be pigeonholed in our own little bailiwicks. We may be most effective in doing the job we can do, but all the time there is the frustration which arises from the fact that we know what we do is not enough to accomplish the goals which we set for ourselves. If we try to increase our effectiveness by restricting our goals, by retreat, then we must narrow our concern to facets of the total person. The alternative is to develop ways of working with other professional personnel, ways which will tend to develop the kind of communication and understanding which makes a community approach to our problems possible.

The East Bay Public Health Nursing Conference, a staff education project in Oakland, devoted to the nurse-patient relationship, was a step in the direction of this kind of community approach. Centered, as it was, around the theme of mental hygiene, the approaches of various specialists could be focused toward a common concern—the individual in his community. Understanding human behavior is an essential part of the professional responsibility of the psychiatrist and the psychologist, of the social worker and the nurse. While their functions within the community vary, mental hygiene principles become a focus wherein each of these disciplines may serve not only as a set of special skills, but as a source of differing, though related, experience. It was this realization which prompted the planning committee to avail itself of interdisciplinary resources.

Again, even though the event may be enriched by interdisciplinary cooperation, frequently the conference is stalemated by dependence on conventional organization. If one tries to get away from the audience-speaker complex, the horizons of group participation are not greatly enlarged by adding a limited number of people to a panel, and allowing the crisscross of talk of this special group to alleviate the strain of listening for the audience. If one is faced with a one-day stand, the temptation is to pack the conference with as much detailed lectures as is possible, so that one can feel the conference has been successful in administering a full dosage. A full notebook, never again to be opened, and a satiated appetite are usually the take-home pay.

THE PLANNING COMMITTEE sought some means by which basic mental hygiene aspects of the nurse-patient relationship could be highlighted without, at the same time, producing the dead calm and passive resistance which invariably follow a day of preachment. The program as finally developed utilized two approaches with a well thought

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out plan whereby they could complement each other. There was the lecture which was given by the consultant on mental health, a psychiatrist. This lecture provided a specific frame of reference by which all the nurses could get an overview of some of the specific points about which they should be concerned in the nurse-patient relationship. There was sufficient attention given to the attitudes of the nurse herself so that she could judge in what way her own preconceptions about her own role could be involved in the interaction with patients. There was an excellent discussion of how patients frequently see the relationship which they have with professional personnel, with a clarification as to why certain resistances can be anticipated, and the need for "working through" these resistances if one is going to be successful in establishing a productive relationship which reaches goals essential to the health of the individual and the community. The lecture pointed out how insulated professional people become, so that they tend to believe their own values are universal.

IT IS ONE THING to accept verbally the points which one hears in a lecture, but it is quite another to incorporate them in one's own behavior so that these principles actually are put to work. There is a wide gap between the action level and the verbal level of response to an inspiring lecture. We were concerned with the problem of how a framework of principles could be translated into behavior; specifically, in the conference, how we could see in action the principles enunciated on the lecture platform, not because we were going to find in any action a prescribed formula for doing things, but because we were convinced that seeing principles put on trial in an action situation would help us relate theory to practice. It would also help us see more clearly what problems we were likely to encounter in the reality or job situation when we tried to make the principles work. The planning committee decided to use the socio-drama technic for the purpose.

The socio-drama is the establishment of a situation where the participants, or actors, act out before the group a replica of the real life situation. It is similar to the theater in that the participants are in a sense actors, acting out the roles of persons in real life. But the way in which the socio-drama differs, and this is a crucial difference, is that the action is unrehearsed, the roles are played spontaneously, and there is no script. The actors are not professional theatrical persons employed for this purpose, but persons from the group or audience who are interested in a particular problem.

For example, let us take a group of supervisory personnel in a factory. These foremen have assembled because they are interested in "sharpening supervisory skills." A foreman describes his difficulty in working with an employee whom he rated at the quarterly job-rating conference. After a short discussion the foreman volunteers to show the group what this employee is like. Then an impromptu supervisory conference ensues, with the foreman taking the role of the employee, and another group member taking the role of the foreman. The situation is only minimally described: "It is morning. I have called Jones in to talk to him about the job, and his attitude toward other workers in the plant. He is coming to my office now." Then the interaction between the two takes place—unrehearsed, spontaneous, and relatively unstructured.

What is essential to the socio-drama is that it arises out of a real need, a real problem. The participants should be sufficiently involved in order to take the roles spontaneously, and sufficient time should be allowed for the exploration of many different roles and ample opportunity for discussion of others. It takes no special skill to "structure" the situation, only a little imagination, and, sometimes, a lot of nerve!

ALTHOUGH THERE IS no magic in socio-drama, it has two great contributions to make to learning situations where human interrelationships are the focus of attention. First, it gives an action picture of the problem, so that all group members have a common perception, the same picture, of what has taken place. Discussions then are not likely to be abstruse; they are likely to be

concrete. Often the theoretical implications of what might have taken place are themselves more significant than what did take place, and the telling quality of the socio-drama makes these implications the possession of many rather than the possession of a few. Moreover, because it is action, it is "moving," and it moves the group members. What is felt by the participants in the role situation is communicated to the group members in such a way that they too feel as if they were having the experience of the role participants. However, the important gain is not the empathy or identification with the situation as such, but with the discussion, which, after the socio-drama, is likely to deal with real issues. It matters not whether the group members agree or disagree with the issue as they have seen it presented. What is important is that discussion is relevant to the issues. Generalizations about issues and principles can be stated in relation to real problems. They are not imposed, as is so frequently done, without a real context of experience to which they are related.

The other aspect of socio-drama which is equally important is that a socio-dramatic situation is itself productive of insight on the part of the role participants. Frequently the person who presents the problem for the group to discuss has been so involved in the real situation that he has been blinded to many of its most salient aspects. But when the problem is acted out in the role-playing situation, the tremendous weight of a situation having crucial consequence has changed to a replica in all ways except this one important difference: we are not now "playing for keeps." Whereas in the real situation we may be blinded by the emotional intensity of our own involvement, in the new situation both the role participants and the group members observing, although intensely involved, may be sufficiently detached to analyze the situation.

A specific illustration from another group may be used. A teacher of nursing was concerned with a problem which she brought to a study group for discussion. She related the essential facts concerning her problem with a young student nurse. The nurse had been consistently tardy for her appointments, was petulant and difficult to handle, and, although a very bright girl, did not seem to be living up to the potentialities which her intelligence and physique would indicate as her capacities. In a socio-dramatic presentation of the problem the teacher of nursing played her own role, and indicated herself to be an understanding, patient, but firm mentor. Another nurse played the role of the student nurse, and did so in conformity with the original description of this role by the teacher.

Then the leader asked that another socio-drama be presented, with the teacher-nurse playing the role of the student nurse, that is, the roles were reversed. It was here that the teacher made some interesting comments as to why she thought the student behaved the way she did, and what were some of the underlying reasons. As a matter of fact, the teacher related incidents of her own student days and she saw a connection between her own reminiscences and her understanding of this particular situation.

There is no question in my mind that such increased sensitivity and understanding which were shared with the group observing the socio-drama in discussion and analysis, are likely to translate themselves into more skill in supervision. In addition, members of the group had a "real" situation to appraise and their own associations were rich and productive in an analysis of the human relationships involved.

SOCIO-DRAMA WAS NEW to the planning committee, but because the psychiatrist who gave the lecture was familiar with the technic and had been associated with this writer in its use previously, he suggested to the committee that they might like to try it as a part of the conference. The term, socio-drama, conjured all the fears and appeals which are likely to be met in an encounter with something new. If we were to use a new technic the committee members wisely saw that it was essential for them, and also for representatives of the various agencies participating in the conference, to come to the conclave having some familiarity with the technic. This called for a preliminary meet-

ing of group leaders and agency representatives.

How does one communicate to a group what a socio-drama is? By having a socio-drama, of course. The writer, as leader of the afternoon session, presented a sketchy picture of what a socio-drama is. The group then listed on a blackboard a few of the problems which they anticipated the nurses coming to the conference would bring. We selected one, a problem which public health nurses encountered on their jobs, as the topic of the socio-drama. It would aid the reader in appreciating the forcefulness of socio-drama if we could recapture the enthusiasm of this "trial" group, for they were so spontaneous in their participation and so insightful in the way in which they related the socio-drama to their actual work situation. Every one in this group of ten or twelve had participated in a socio-drama before the familiarization session was over. The temptation was to stay long after the scheduled closing time.

While the preliminary meeting insured that the representatives of every agency had become familiar with the technic, we did not decide what the agenda of the group discussion would be. The topics for socio-dramas, we agreed, would come from the discussion groups themselves and might vary, as indeed they did, with the specific small groups. But each of these representatives would be in one of the smaller groups, some of them as group leaders, and they were ready to help the group use socio-drama as a technic.

In accordance with the plan, small discussion groups were to be held after a morning lecture on mental hygiene by a psychiatrist. Each group of 15 to 20 persons was to decide which problems they wanted to discuss. The writer presented a short description of the socio-dramatic method before the assemblage broke up into small groups. There was to be a final reassembling for the evaluation session and sharing of experiences.

Because we had such a large number of participants, it was necessary to recruit as group leaders a number of psychology students who were familiar with socio-drama and particularly interested in group leadership technics. They were assisted by representative public health nurses. The psychology students were not familiar with the public health nursing field, and for the most part were unable to attend the lecture in the morning, but had used the socio-dramatic technic in a class laboratory situation and were interested in functioning as group leaders.

THE USE OF THE socio-drama perhaps can be indicated best by a description of one of the small group sessions. Fifteen public health nurses are assembled in a small room. A team of two, a public health nurse and a clinical psychology student, identify themselves, and the group is quickly oriented to the group task of getting on the blackboard some of the problems which members feel are significant in the light of the morning talk on mental hygiene.

A large number of problems are listed, and the two which seem to receive a great deal of recognition by the group center around "interviewing process" and "how to get people to follow through." The leader then asks for a specific situation to illustrate the problem. This situation is selected: A nurse tells a working man that his diagnosis is tuberculosis and tries to help him work out plans for treatment and for care of his family. Before proceeding to the socio-drama we secure the facts about the real situation; that is, the age of the man, the number of dependents, his attitude, et cetera. Then the specific situation described by the public health nurse is reenacted, with one nurse taking the role of the man, and someone taking the role of the nurse. Chairs are arranged so as to convey "reality" in the situation, and the persons taking the roles are asked to talk and act spontaneously, the nurse carrying on the interview as she thinks it should be, and the "man" reacting as he thinks he would.

George Herbert Mead has indicated that insight is the "ability to take the role of the other." In this situation the nurse who took the role of the working man was able to see all of the fears, associations, and resistances which the man would have to such a diagnosis. The question of how one introduces the topic, the problems of placing the diag-

nosis in the context of the man's innermost feelings, the difficulty in understanding the man's perception of "tuberculosis" and the emotional connotations—all of these were discussed because they seemed to arise directly and dramatically from the socio-dramatic experience. The principles of mental hygiene so admirably set forth in the morning lecture became a frame of reference by which one could evaluate the relationships as seen in the socio-drama. The lecture helped the group members become sensitive observers. A man's inability to follow advice is seen, not as wilful failure to follow orders, but as a deep resistance against changing a fundamental conception of the self—change from a well man to a sick man.

The role of the nurse as a sympathetic human being is to understand this particular man and help him change, in accordance with his ability to overcome his resistance by understanding his own feeling and attitudes. She must not succumb to the temptation to try to force him to comply with the standards of care and treatment which are indicated, but which can be communicated to him only after there is a fundamental acceptance of the new situation.

There were many situations used as socio-dramas: interpretation of illness, overcoming prejudices to certain modern preventive and sanitary measures, dealing with significant members of the household, such as the foreign-born mother who resists the new ways of baby care which the nurse is teaching to her daughter or daughter-in-law, getting the family to use the community facilities for health—all of these situations and others which involve the nurse's relationship to her patients were explored.

THE SOLUTIONS to problems varied. There seldom is an all or none answer to any of these problems of human relationship. But it was our task to see them as problems of human relations, not as problems of nursing only, nor only as problems of medical care and disease prevention. It was our assumption that in observing situations which provoked thinking and discussion, public health nurses would be stimulated to find their own solutions, because they had seen the essential issues raised; in fact, what is more important, they had been involved in raising the issues. The group discussions were always intense and productive of many insights and alternative slants. Nurses volunteered readily to play the role, either of the nurse or the patient, in several ways. These variations in role enactment are of themselves rich in bringing forth creative thinking about problems of mutual interest.

Much of what is essential in any professional service has to do with what is involved in the personal relationship. People are never really patients or clients, they are always intractably human. They seldom do what we want them to do; they do only what we would do if we were they in their particular situation. So if professional services are going to be effective, especially in the educational sense, if people are going to "follow through," we must understand them in the light of their basic and fundamental motivations, and then adjust our particular methods to function in accord with this understanding.

Socio-drama has a contribution to make as a method for exploring the possible motivations and needs which we may find in human beings. In addition, it gives the professional person some situations where she can actually "practice" her skills in human relationships. Whereas in all machine skills we provide a period of practice before one becomes a mechanic, in the field of human relations, the most complex and elusive of all fields for the practitioner, we find little opportunity to practice.

The final session of our conference convinced me that we had all received much help from the socio-dramatic method. But it was just a beginning. For every problem discussed there were many which pressed for statement. It was my hope that the method would be taken up by some of the nursing staffs as part of their own in-service training. In some cases this has been done.

THERE IS A lingering timidity on the part of many persons to use the method. The common assertion is this: "I am no good at acting." This may be true, but it is irrelevant.

The socio-drama calls for spontaneous reactions and as such does not call on histrionic ability. Instead, my experience has led me to believe that, in many cases, theater experience is a real barrier to spontaneity, therefore a disadvantage. What is essential is that the problem one works on is sufficiently central in character to challenge one's ability and that the group are sufficiently objective to be willing to look at each other without blame, regarding whatever is done as a potential contribution to thinking. Even actions on the part of role participants which merit real disfavor in view of professional standards of human understanding should be accepted in the light of what they can offer for analysis as to why certain practices should be preferred over others.

The psychology students were frightened before they started working with the groups. True, they had enjoyed experience with socio-drama, but this was under the sheltering arches of the academic halls. Now they must try their new "tricks" before grown people! It was interesting to me to see how many of them came from the experience with the excitement and even wonder of how easy it had been compared to their apprehensions. Once the group were able to settle on a problem which they saw as their own problem, common to all members, it was not difficult for the students to formulate their socio-dramas. Moreover, students have not been insulated from the many group occasions where they see passivity instead of participation, immobility instead of involvement. And so it came as a great surprise when they saw these groups aroused to active participation. But of course the students too were active participants; they were not passive observers.

Again, there is no magic in socio-drama. Its merit lies specifically in its ability to provide a facility for the involvement of persons in a task. It helps them hurdle the barricade of abstruse, complicated, and defeating definitions which often obscure discussion and prevent participation. It offers an opportunity to the group to mobilize the intellectual forces around a common perception and a central issue.

SUMMER COURSES

Summer courses in universities having programs of study in public health nursing approved by the National Nursing Accrediting Service in addition to those listed in PUBLIC HEALTH NURSING for April (p. 234) are:

ILLINOIS

Chicago. Loyola University. Intersession, September 11-13, the Geriatrics Program—Margaret Ranck. September 13-15, the Cancer Program—Sibyl Davis.

For further information write to Essie Anglum, Chairman, Department of Public Health Nursing, 820 N. Michigan Avenue, Chicago 11.

NEW YORK

Brooklyn, St. John's University. First session June 12-August 4; Second session July 5-August 11. Courses offered: Educational Psychology; Child and Adolescent Psychology; Sciences; Sociology.

For further information write to The Dean, School of Nursing Education, 303 Washington Street, Brooklyn 1.

Syracuse. Syracuse University. July 5-August 11, selected courses from the major program in public health nursing leading to a baccalaureate or master's degree. June 5-June 30, Field Practice in Methods of Teaching Home Nursing. July 5-July 22, Study in Clinical Aspects of Tuberculosis Control. July 24-August 11, Public Health Aspects of Tuberculosis Control Program. July 31-August 18, Integration of the Social and Health Concepts in Nursing. A three-week workshop designed to assist teachers and supervisors in schools of nursing and public health nursing agencies to gain an understanding of the philosophy, principles, and methods of integrating social and health concepts in the teaching of nursing. Instructor—Hedwig Toelle. Workshops and institutes in Health Education, Cerebral Palsy, and Nutrition will be offered by other colleges in the university.

For further information write to Ruth E. TeLinde, Director, Department of Public Health Nursing, College of Medicine, Syracuse University.

The ABC's Of The Merit System

Principles and Practices

CHARLES B. FRASHER

THERE IS no real difference between a merit system of personnel administration and a civil service system. Each is a comprehensive program designed to promote efficiency and economy in government through the recruitment of workers and the establishment of adequate working conditions. In some states, cities, and counties the civil service system is provided for in the constitution, in general or specific laws, or in ordinances. In other political subdivisions a merit system is provided for in agreements called rules and regulations. The systems are designated by different names, such as civil service, merit system, personnel departments, and the like. To personnel workers they are known as the central personnel agency.

In 1883 a reform movement which had been active for a number of years resulted in the development of a merit system for federal government workers. This system is administered by the U. S. Civil Service Commission and its regional offices. Some states and cities organized central personnel agencies after this time, but until the middle 1930's relatively few states and cities had civil service systems.

The passage of the Social Security Act in 1935 spurred the development of merit systems for workers in welfare programs, and its amendment in 1939 encouraged the development of merit systems for workers in public health. Today 16 states have civil service coverage for most, if not all, of their governmental employees, and 32 states provide such coverage for the workers in programs utilizing federal health, welfare, and employment funds. In some of the latter states there is an encouraging trend to broaden the coverage to workers in other programs.

Civil service has not been developed just to protect the worker nor, on the other hand, to facilitate the job of the employer. Basically, it is a plan to promote efficiency and economy in governmental administration through a program of personnel management. Traditionally, governmental workers have been selected on the basis of patronage—the appointment of individuals on some basis other than merit. This has been done by politicians in order to strengthen their chances for control of governmental functions. In order to further the cause of administration by merit, it will be necessary to convince our political leaders of the advantages to them in the promotion of good government through the use of qualified workers. Many readers may be unaware of the problems of "selling" merit systems. On the other hand, there may be some readers who still must be themselves sold on the idea of a merit system. Some years ago a nurse was asked, "Do you have any nurses working in the county who belong to X political party?" Her reply is a classic, "Oh yes, we have two, but you know there is a shortage of nurses."

In discussing the principles underlying the objectives of a merit system and some of the methods whereby these principles are put into practice, only three broad general policies need consideration. These are recruitment, selection, and working conditions.

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Recruitment

The slogan, "Let the most meritorious serve the government," describes the principle of recruitment under the merit system. Recruitment ideally should be carried on among those workers qualified to meet the responsibilities of the job. This involves certain steps

1. *Classification and description of jobs.* Prior to recruiting for governmental positions the job should be thoroughly investigated and described in detail. Qualified observers should determine the qualifications necessary to carry out the duties, and the position should be fitted into the general scheme of the agency. This process has been discussed in detail by Locke[1] and others. Your own merit system agency will be glad to discuss the operation of such a process with you.

2. *Advertising.* In order to attract potential workers, they must be informed about the job and must develop an interest in working in the specified agency. This is no small order and careful planning must precede this phase of the recruitment program.

Traditionally, civil service agencies have utilized the method of describing the job in general terms, listing information relating to salaries offered, time and place to file applications, examination weights, right of appeal, and the like. Such information might better be withheld until initial interest is aroused. Better advertising methods should be employed in order to attract those best qualified. Other methods being used are attractive folders listing jobs, training, and career opportunities, radio and newspaper advertising, announcements where persons in certain categories gather, such as state and district conventions. One state utilized the services of a public relations agency and was able to fill quickly all positions in a certain category below the professional level. Another merit system jurisdiction selected the names of 3,500 doctors (those with masters' degrees in public health, those licensed to practice in the state, those who formerly lived in the state, et cetera), and sent each a carefully prepared, printed statement. The results were practically negative. Another state, during the early days of the war when the shortage of nursing personnel was evident, secured the assistance of a volunteer nursing advisory committee and, using only residents of the state, circulated an invitation to employment which resulted in four times as many applicants as there were jobs. These and other experiences lead to the conclusion that personalized recruitment will be necessary if we are to attract the best qualified worker to governmental jobs.

The best recruitment today is carried on when the merit system agency and the health workers are jointly developing methods to solve the shortage of personnel problems. The merit system agency might provide the *how* of recruitment and the health workers the *where*. A nurse can probably be more effective than anyone else in convincing a prospective nurse employee of the advantages of a particular position. But she should have all the resources of the merit system agency to assist her.

Selection

Once prospective employees have been recruited and have shown an interest in the job, the merit system agency has the problem of classifying them, that is, of listing them in the order in which they will most likely be able to perform the job effectively. This is called the examining process and generally has three to five parts.

1. The *written* examination is designed to determine the degree to which candidates possess knowledge essential to the duties. Material for written examinations is available from several sources. Some merit system agencies have staff members in their examination division who write examination questions; others call upon qualified persons in the professional field to help prepare examination questions. The Civil Service Assembly (which is to personnel workers what the NOPHN is to public health nurses) maintains an examination exchange service from which examining agencies can borrow examination questions from other states. The Division of State Merit System Services of the Federal Security Agency provides examination material for social work, clerical, and other positions; the Merit System Service of the American Public Health Association provides complete ex-

aminations for public health positions. The latter uses the services of about 2,000 persons scattered throughout the country and has available an exhaustive examination service for the selection of public health workers. Thus far, limited use has been made of the professional examination agencies which provide standardized examinations, probably because they have not as yet received proper acceptance by workers in a specific profession. However, there seems to be a growing use of such services specifically for the so-called intelligence, performance, and some aptitude tests, particularly by city agencies. Tests such as those prepared by the Merit System service are by and large achievement tests and tend to measure specific achievement in one of the fields of public health.

Essay examinations or the "free answer" type are being used diminishingly, probably because it is difficult to get two or more persons to agree on the order of the final scores. Objective examinations are being used to an increasing extent.

Arguments are often heard as follows (by no means limited to nurses): "Why should I take a written examination? I have been registered by the board of nurse examiners. My qualifications have been determined by the board." Merit system agencies have no quarrel with this premise. But their job is different from that of the board of nurse examiners. Their responsibility is (a) to examine for qualifications which generally are higher than those required for state registration, and (b) to determine the order in which applicants possess knowledge and judgment which are important to the job. Their best instrument to determine these facts is the written examination. Preventing merit system agencies from using the written examination is like asking the doctor to take your temperature but telling him to use the back of his hand rather than that "newfangled clinical thermometer."

2. The *oral* examination is one of the methods used to evaluate personal qualifications, especially when professional achievements have been measured by a written examination, and also when the position requires working with others on a cooperative basis. Very little research has gone into studying methods currently employed, and the oral examination must be used with great caution. Usually three or more examiners carry on a relatively short interview with the candidate. The problems of objectivity and reliability in this kind of an oral examination have been described in detail.[2] We need note only that it is a difficult kind of examination to arrange, and that the results may not always classify candidates in proper order.

A new technic is under investigation—the group oral interview.[3] This involves gathering all of the candidates in a room at the same time (usually not less than four or more than eight) and allowing them to discuss topics among themselves. The examiners or the raters sit in the room but do not take part in the discussion. The discussion lasts anywhere from one and one-half to three hours. One of the advantages claimed for this method is that the best and the poorest candidates are more easily selected than by the single or "man-to-man" interview.

3. *Rating experience and training* is an attempt to measure the background of candidates and to determine their future effectiveness on the basis of their education and experience. The methods in use at present give greater credit for recent as opposed to remote experience, and seem to give more credit for the length of experience than for the quality of the experience. It is a quantitative rather than a qualitative judgment. It is well appreciated that the graduate of the top of a class of nurses in a poor or small school would probably be a better person than the graduate from the bottom of the class in a good or large school. Also, we know that all workers in a specific agency do not gain the same degree of competence under the same supervisor. Some agencies have established entrance qualifications and those who possess at least minimum qualifications are passed, while those who possess less than the minimum are failed. Until a more valid method is developed for evaluating education and experience the latter plan for rating backgrounds seems more justified than giving equal credit to good and poor education and experience.

4. A *performance test* may also be utilized, especially where the job calls for measurable performance. Hilbert and Brody discuss this in their forthcoming book.[4]

5. The *work test* or the *probationary* period—a specified period of time during the first months of employment when a worker is observed closely to see if performance is satisfactory is the final factor in the selection program.

This summarizes the methods in use by merit system agencies for the selection, or, rather, the listing of candidates for governmental positions. The final selection is usually the privilege of the appointing authority.

The Hoover Commission Report recommends that, instead of preparing lists of candidates in rank order according to examination results, candidates be grouped in categories and that selection be made from within the groups. This seems to be a criticism of the adequacy of examinations. The preparation of groups of candidates rather than a list in rank order is proposed to resolve the inequities which result from improper examinations. It might have been better had the commission recommended extensive research into examination technics and adequate financial support to develop examinations which would be both valid and reliable.

It is debatable whether or not the best qualified professional workers will be attracted to governmental positions as a result of the traditional recruitment and examination technics. These take the form of announcements of job openings, scheduled examinations of various parts, and a period of waiting for qualifications to be verified and lists established. The lapse of time between the original announcement of an examination and the preparation of the final list of candidates is as short as three weeks and as long as three to six months. In some jurisdictions, particularly where candidates appeal examination ratings, the time lapse has been known to be a year or more. The best candidates will probably not wait for the offer of a job and when the final list is established it is likely that persons whose names appear at the top of the list will be employed elsewhere.

Some merit system agencies, recognizing the loss of good candidates by reason of delay, have developed new technics designed to speed up the recruitment and selection process. These technics are known as *continuous recruitment, periodic examination,* and *open registers.* Let us see what they entail.

Most civil service laws require that examinations be announced two or three weeks in advance of the examination. The apparent purpose is to notify all qualified persons of the job opportunities and to secure the attention of large numbers of qualified candidates. Through announcement of continuous recruitment and through acceptance and processing of applications as they are received, the legal requirement of adequate advance notice to candidates is met. This plan is particularly desirable where there are periodic vacancies in positions. It is not a desirable plan where there is only one position, such as director of public health nursing. In such a *single position class* an intensive nation-wide drive would probably produce better results. However, where persons are needed whenever they are found, a plan of continuous recruitment would prevent the situation from occurring in which an available applicant is told, "We are sorry, examinations for the position in which you expressed an interest are not scheduled for the near future. Your application will be placed on file and you will be notified when examinations are contemplated." Rather, the application would be processed immediately and one of the series of periodic examinations would be given.

Periodic examinations mean the administration of examinations whenever there are applicants for existing openings. For example, examinations for stenographers and clerks might be held each Wednesday night and Saturday afternoon—times when workers are free to take examinations. For public health nurses it would be appropriate to hold examinations as applications are received—even for a single public health nurse. One merit system agency requires that there be three or more candidates before an examination can be held. Such a policy is not indicated since candidates are not necessarily matched against other candidates. Rather, they are judged on the basis of established qualifications and ex-

amination performance. Qualifications should be established at a sufficiently high level to eliminate those who cannot perform satisfactorily, and examination should be used upon which some previous evidence has been gathered in order to determine a passing mark. Such data are routinely collected by the Merit System Service of the American Public Health Association and by the National League of Nursing Education.

The final phase of the continuous recruitment-periodic examination-open register technic involves the placing of names of examined candidates upon lists. Open registers imply that the name of a successful candidate is put on the list at an appropriate place according to her score. Sometimes the written score and the grade for education and experience are combined. It is unbelievable that some agencies routinely place all new names at the bottom of the list or below the name of the candidate who had the lowest score on a previous examination! This practice, carried out probably in the mistaken belief that the agency owes some obligation to persons according to the date of their application, would seem to defeat the purposes of the program; namely, to recruit the best qualified workers, to speed up the appointment process, and to make workers quickly available to the appointing authority.

Working Conditions

Finally, principles of merit system administration include the conditions under which persons operate or carry on their work. The working conditions should be as ideal as it is possible to attain. They are discussed in detail for public health nursing agencies in the NOPHN's publication on personnel policies.[6] Those which are of special interest to merit systems will be mentioned here.

1. *Equal-pay-for-equal-work* implies that workers carrying on similar duties with similar degrees of responsibility should receive similar pay. No discrimination should be made for sex, race, religion, political activity, or other factors which are unrelated to the jobs. But there are real problems connected with the principle of like-pay-for-like-work. Merit system agencies have developed *compensation plans* which are designed to carry out this important principle. A number of factors are studied in order to develop a compensation plan, among which are level of responsibility, importance of tasks to the total program, preparation required, occupational risks, current rates of pay, supply and demand. A final plan is prepared which sets entering rates of pay, intermediate steps for satisfactory service, and maximum rates. In spite of the great care which has been exercised in setting up compensation plans, many of them have been developed by the by-guess-and-by-golly method. What is urgently needed is an adequate yardstick to measure the value of a program of work to the employing agency or to the political subdivision, and another yardstick to measure the effectiveness of a worker. Who knows the economic value of a school health program, an immunization program, a public health clinic or a home visiting service? Certainly they have a place in the economic scheme, but thus far their economic value has not been measured. And we all know that workers assigned identical duties are not equally effective in carrying out those duties. The principle of equal-pay-for-equal-work is sound, but technics for measuring equal work are badly needed.

2. *Tenure*, or the right to hold a position, is another principle of working conditions. The principle was important when patronage played so large a part in appointment to governmental jobs, but it has been badly interpreted, so much so that administrators often have been reluctant to dismiss even incompetent workers. The correct interpretation should be that a worker is retained in a position so long as the work is necessary and the worker is performing in a competent manner. He should be released for just cause only. The right to a position exists only under these conditions. Good workers are attracted to positions in agencies which have established reputations for providing continuity in employment, and likewise workers shy away from those agencies in which poor employment practices maintain. An agency might, therefore, improve its chances for recruiting the best workers if it were to operate so that it would get a reputation for keeping

good workers and for releasing poor workers.

3. The *right of appeal* is another concept in our democratic form of government. It is termed, "the right of appeal from any and all personnel actions." Usually the Civil Service Commission or some other legally constituted authority listens to appeals from dismissal, transfer, demotion, layoff, and disciplinary action, and either makes a recommendation or makes a final disposition of the appeal. There seems to be justification for such a principle in democratic government where policy-making officials are appointed by one system and workers are appointed by another. It should be stressed, however, that employees as well as employers, such as appointed officials who have no control over certain policies affecting their employees, should have the right of appeal from certain other forms of personnel actions such as mileage rates, travel allowances, lighting, ventilation, heating and circulation, facilities, et cetera. Among the employees a staff council often acts as the body for hearing or for clearing appeals from working conditions.[6] There seems to be little, if any, provision for formally hearing the appeals of the above-mentioned employers.

During appeals it is often the custom for appellants to have the right to be represented by counsel and to be heard by an impartial body of citizens which attempts to promote justice in employment conditions.

4. *Economic security* is the final principle. Workers are entitled to some assurance of economic security when they reach the period in life when their best productive years are behind them and where their performance on the job would hinder the progress of the program. A number of state and local governmental bodies and volunteer agencies employing nurses have adopted retirement plans. Usually, it is the custom to provide for contributions by both the employer and the employee, and to state a voluntary and a compulsory retirement age. In regard to the proper age for retirement, again something is lacking. Not all workers are ready for retirement at the same chronological age. A physiological age or the period at which production is uneconomical might be a better determinant of the time for retirement.

These principles of recruitment, selection, and conditions of work are basic to all programs which involve the employment of human beings. While official agency employment has been stressed in this account, the principles apply equally to private and industrial agencies and groups. Many voluntary nursing agencies have already incorporated these and other basic principles of personnel administration into their employee programs.

It is not to be construed that civil service agencies concern themselves only with these basic principles. Many of them are reaching into other phases of personnel management, including the analysis of administrative management, training programs, programs of public relations, programs designed to improve the economic status of employees—such as cooperative purchasing programs, low cost credit unions—social programs of various sorts, and programs of research into merit system methods and technics. Nor is it to be construed that all civil service agencies carry out in practice the important personnel policies stated here. On the contrary, civil service programs, regardless of legal requirements, are no better than the persons responsible for translating the legal requirements into action. It is understandable that some civil service programs are not operating efficiently because of the caliber of person appointed to operate the civil service function of government.

In order to have good civil service actually operating on a merit system basis it is important to have the necessary basic legislation; an advisory board of citizens who are sympathetic to the principle of merit in government and who are willing to assign administrative responsibility to qualified management personnel; an experienced and trained staff with sufficient funds to operate adequately; cooperation by the operating agencies, and active support of the merit principles by employees and citizens. A qualified personnel officer in the operating agencies sits as liaison between the operating agency and the central personnel agency. In this connection a panel of professional health workers recommended that "personnel administration is a specialty

and in every large health organization . . . there should be a special office of personnel administration, this office to be directed by a well trained and competent personnel administrator."[7] The appointing authority must be convinced of the value of the principles of merit administration and the major governmental authorities must give their support.

The above is a rather all-inclusive statement, but in order to have a successfully operating merit system people must want it to work. The merit system of Louisiana is a good example of an agency which seemed to have all the chips on its side—good legal provisions, excellent commission, qualified and adequate staff, a good budget, support by most of the operating agencies and employees, a strong citizen's group, and verbal affirmation of the merit principle by candidates for office. In spite of these, the program was abolished on a state-wide basis. A merit system is a cooperative enterprise needing the best support it is possible to assemble.

In order to be increasingly effective, a merit system must scrutinize its practices periodically and change them according to the best judgment as to how these practices can be most effective. A proverb says, "Though a thing has been false a thousand years it yet is not true." Applying this to merit system practices, it is no proof that a traditional practice which has existed for years is still the best practice. Governor Bowles of Connecticut pointed out to civil service representatives the need for a continuous study of personnel practices in government if a personnel agency is to make its proper contribution to the business of government.

The nursing profession took the leadership among health professions in incorporating merit principles of personnel administration in health programs. Their support and critical suggestions are still needed—at all levels—if the merit system is to solve the problems of personnel administration which are encountered in the course of contributing to social welfare.

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[5] NOPHN. *Personnel policies for public health nursing agencies.* Revised 1950. 75c.

[6] Ibid.

[7] High points of the Boston meeting. *American Journal of Public Health,* January 1949, v. 39, p. 10-23.

THE STANDARDS OF HEALTH will be raised only if there is a constant and dynamic relationship between the citizen in all walks of life and the health authorities which are to serve him. Each person must familiarize himself with the facilities which have already been established to protect him against disease as well as to promote his physical and mental well-being. He must learn how to take advantage of these services for his own sake and for the benefit of his fellow human beings. But he must go one step further. He must also know about the needs of the community which are still to be satisfied and actively support the health authorities in their endeavor to create the moral and financial means which are necessary to cope with the still unsolved problems.

The World Health Organization, dedicated to the concept of worldwide solidarity in health matters, is ready to second that effort by providing the national authorities with the internationally available knowledge of modern skills and technics. It can do no more. The primary impulse for the betterment of health must come from the citizens themselves, individually as well as joined in community action.

—BROCK CHISHOLM, M.D.
director-general, WHO

The Prevention of Deaths From Prematurity

E. STEWART TAYLOR, M.D.

SINCE 1946 those doing obstetrics and those doing pediatrics in our University Hospitals have concentrated upon reducing fetal mortality and morbidity due to premature birth. We do not suggest that we have a formula for preventing premature labor. We do, however, in our teaching and practice of obstetrics, try to emphasize prolongation of gestation in certain patients where the maternal complication might otherwise lead to early interruption of pregnancy.

In an article* published from this Department, it was demonstrated quite clearly that premature fetal survival was dependent in great part upon the condition of the infant's mother. If the mother's pregnancy is complicated with an acute infection, breech, toxemia, placenta previa, or placental separation, the mortality rate is four to five times that of infants born of healthy mothers without pregnancy complications.

It has seemed to us, therefore, that our greatest efforts should be directed toward the management of the antenatal period so as to prevent maternal complications. Naturally, all such maternal complications cannot be prevented. Placenta previa and breech are not preventable. However, pyelitis, other acute infections, toxemia of pregnancy, or congestive heart failure may be controlled or prevented with adequate antepartal care. If these conditions are controlled fetal survival will be improved. Our main efforts toward reducing premature infant deaths should therefore be in the antenatal period.

After labor has started there is nothing that may be done to stop premature delivery. There are a few conditions, however, where the interruption of pregnancy complicated by prematurity can be forestalled. For instance, not infrequently it is possible to prolong gestation in cases of placenta previa or premature rupture of the membranes. Such delays in delivery are now possible and safe because of adequate hospital facilities, blood banks, and the antibiotics.

Indigency also predisposes to premature delivery. Our ward patients have premature delivery as a complication two to three times more frequently than our private patients. It is our feeling that substandard diets and poor housing have considerable to do with the problem. Inadequate diet leads to a poor nutritional state, anemia, loss of resistance, and acute and chronic infections. Many of our indigent patients develop pyelitis and other infections that definitely predispose to premature delivery. If we were able to correct substandard diet, control infections, and improve the state of personal hygiene of our indigent patients we believe that a large number of premature deliveries would be prevented.

In addition to the need for improved antepartal care to prevent or control maternal complications, the need for adequate diet and maternal hygiene, and the problem of the medically indigent, the next important concept in our total program is a combined awareness of the prematurity problem through cooperative efforts on the part of obstetricians, pediatricians, nurses, social workers, nutritionists, and public health personnel. The obstetrician has important functions in the management of labor and delivery. His effort is to make the labor and delivery as atraumatic as possible, and to do it with as little actual or potential depression of the infant's respiratory

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* Taylor, E. Stewart *et al.* Effect of obstetric difficulties and maternal disease on premature infant mortality. *Journal of the American Medical Association,* November 26, 1949, v. 141, p. 904-908.

apparatus as possible. It is extremely important that no maternal analgesic drugs be used during labor. Regional anesthesia must be used for the delivery.

At the time of labor the pediatrician must be called to the scene. He is briefed on the maternal pathology that may be part of the picture, and is at hand to help resuscitate the newborn premature and to take over its neonatal management.

The University of Colorado, in cooperation with the Colorado State Health Department, through a grant from the United States Children's Bureau, has established a Premature Center that has functioned for the past two and one-half years. The organization, function, and staffing of the Center have been outlined here. In addition, teaching and research on the subject of prematurity are inherent in the program. The Center serves not only our own obstetric service but acts as a referral center for outside agencies and doctors.

For the past four years, deaths from prematurity in the Colorado General Hospital, the institution which contains the Premature Center, have been consistently under 10 percent of live-born infants weighing less than 2,500 grams at birth. We are proud of this record and believe that its attainment is due to the importance placed upon the life of the premature infant by all the members of the team.

CHILD HEALTH — A NATION'S WEALTH

THE WEALTH OF A NATION lies in its children. It is an interesting fact that in the absence of all other data the general state of a country's health can be gauged by the death rate among its babies. There is no more eloquent evidence of the great inequality of opportunity between human beings in different parts of the world than the fact that infant mortality can vary from 30 per thousand live births in some places to over 300 per thousand in others.

The chief reason for these wide variations is the fact that in this field as in most others there is a considerable time lag between technical advances and their practical application. In the field of maternal and child health this lag is perhaps least justifiable.

There are two most important ways in which work is being done to improve child health. The first is through nationwide organized effort to raise the general standard of living, since health generally, and the health of children especially, accurately reflect the social and economic conditions of the community. Such an effort is accompanied by measures making full use of known preventive technics against disease. The second is through individual effort in learning to use the available resources of the community and to build sound attitudes and health practice in the family, especially for the benefit of children.

It is important to remember that community health services—however good they may be—can never do the job alone. Accidents are responsible for many thousands of children's deaths each year. Most of them occur at home. At least fifty percent are estimated to be preventable.

If community health services are to help everyone, everyone must know what organized efforts for child health are being made in his own community. Only in this way can the individual profit by them, support them, bring others to these benefits, and thus bring better and quicker results for a healthier child population.

WORLD HEALTH ORGANIZATION

HOMEMAKER SERVICE TO MOTHERS AT THE TIME OF CONFINEMENT

MAUD MORLOCK

"WHAT ABOUT THE CHILDREN?" That is many a mother's first thought when the time approaches for her to go to the hospital to have another child. Perhaps grandmother, or an aunt, can stay with the children. But all too often there isn't anyone. And when no grandmother or other member of the family circle is free to take on the exacting task of keeping her household going, then the mother's question has an anxious note.

What about the children is our question, too?

Homemaker service, which is one answer to this question of many mothers, has several facets. It is frequently selected as the best way to meet situations that arise when a mother has to be away from home or is unable to carry on her usual duties there. It may be offered to households made up of adults as well as to families with children. It is a useful service to old people. But here we shall consider only service to families with children or to parents having their first child, and only in connection with the mother's confinement.

It is difficult to say who gets the most out of homemaker service—mother, father, or children. All benefit, though in different ways. But the sum of the benefits is that it keeps the family intact.

Mothers speak of various ways it helps them, but one way stands out above the rest. It gives a mother, they say, the kind of confinement that childbirth is meant to be. It gives her freedom to concentrate on bringing her baby into the world and, when he is here, to concentrate on getting acquainted with him. Rested and unworried, she can have the serene relations with her baby that give him a good start.

A homemaker was assigned recently to the wife of a high-school teacher, who was having her third child. The homemaker's first visits to the home were 2 months before confinement when the doctor wanted the mother to be off her feet for a while. Then the homemaker took over again 3 days before the mother went to the hospital for delivery. When the baby was 6 weeks old, the mother was ill and the homemaker went back again.

This mother said that every phase of her confinement was easier because she did not worry about what was happening at home. She knew her family was safe, happy, well fed. She knew that her husband could afford the small charge for the service. She did not have to look forward with dread, as she had previously, to taking up her work before she was equal to it. For the first time she enjoyed having a baby and felt she was able to help her children and her husband enjoy the arrival of a new member of the family, too.

A father may feel the full brunt of planning for the care of the children during his wife's confinement. Many fathers try to hire a worker to stay in the home but cannot find a competent person. Others cannot pay the cost of hired help. With homemaker service, fathers, too, benefit by freedom from worry during working hours because they know the children are in good hands.

A father has unusual responsibilities in the

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home during the homemaker's service. He takes over when she leaves for the day and on week ends. When he first makes arrangements with the social agency that provides the service, this is fully planned between the father and an agency caseworker. The experience, even if hard, may be very rewarding. A father may come closer to his children at this time than at any other.

Children benefit because homemakers plan to keep the atmosphere of the home during this out-of-the-ordinary time one of assurance and affection. Transplanting children to a foster home for a short time when their mother is away for her confinement may be a traumatic experience for them, just as being farmed out among relatives, friends, or neighbors may be. But being left at home, uncared for because their father must go to work, is worse. And to have an older brother or sister stay away from school and try to run the household is not good for them or for the school ager.

Young children are likely to suffer from fears aroused by their mother's absence, especially if there is tension because the situation has not been planned for. If they stay in their home with a responsible person to care for them, these fears may not arise or can be dealt with more easily.

THE HOMEMAKER HAS FULL STATUS as a staff member of the social agency that employs her. She is paid a living wage in line with her responsibility—higher than the scale usual in domestic service. She works 40 or 44 hours a week. If the parents are able to pay all or part of the cost, they pay the agency directly for the service.

Although the service is available to families in all income groups, most of a homemaker's assignments are to low-income families. Most agencies, with a limited amount of service to give, prefer to serve families of small means. These families are obviously at a disadvantage when they try to obtain anything approaching skilled service like this.

In the short-time care we are considering, given at the time of the mother's confinement, the homemaker's job is to keep the home intact for the children. She is expected to accomplish this without changing the family's way of living. As one homemaker expressed it, "We do it their way."

It is best for the homemaker to take over her duties several days before the mother goes to the hospital. She can then become acquainted with the children and can learn the family pattern from the mother. The mother's confidence in the homemaker when she sees her in action is likely to be communicated to the children. Before their mother leaves, they may have gotten over thinking of this new person as a stranger. The homemaker stays until the mother is well able to take up her duties.

What qualifications should a homemaker have? She must be able to do the whole gamut of household management on a small budget; she must know food values and the preparation of prescribed diets. She must have the wisdom and experience that enable her to take responsibility for children during their parent's absence.

A homemaker must understand people and must be able to keep her poise under trying circumstances. She must be adjustable, able to go easily from one home to another. She must be sensitive to family situations. She must be able to gear the degree of responsibility she takes to the needs of a particular family and to changing conditions within the family, such as, during the gradual recovery of the mother. Of course, she gets help from the caseworker in all this, but she must be able to use that help.

A few sketches of situations in which homemakers played a part may show better than general statements what a homemaker does:

When Mrs. C was 6 months pregnant she had an attack of pneumonia. Because she had a rheumatic heart, the doctor sent her to a hospital at once. Her husband could not stay away from work to care for the four children, ranging in age from four to eleven. A great-grandmother of 82 tried to keep the household going but found the effort too much for her.

At this point a homemaker entered the scene. Each morning she arrived in time to get the children off to school. Very soon she found that the mother had been having difficulty managing her household on her husband's low wages; she had not been feeding the children well. They were completely disinterested in food. The homemaker concentrated on giving the children nourishing

meals (at low cost), and soon they were enjoying her appetizingly prepared dishes.

Mrs. C went through her confinement well in spite of the complications. Her doctor attributed her good condition to the fact that she had been able to rest in the hospital with an easy mind before the baby was born.

The homemaker stayed 2 months, until Mrs. C had regained her full strength.

The medical social worker at the hospital where Mrs. G had been delivered of her first baby asked for service for her when she was about to return home under difficult circumstances. The young woman was suffering from multiple sclerosis and could not handle the baby with safety.

Doctors had explained the medical diagnosis and prognosis to the husband but he had not yet been able to face the fact that his wife would be paralyzed to some degree. While she was in the hospital, he would not consent to her being placed away from home.

A homemaker took care of the home for a month. Meanwhile, a caseworker was helping the husband and wife to find a solution for their grave problem.

The hospital where Mrs. B had given birth to twins asked a family service agency to send a homemaker to help the mother, who was already at home. The housework and the care of a young child and three babies (a one-year-old in addition to the twins) had brought her to a physical breakdown. She had never learned to carry out her duties.

A homemaker was assigned to this family for several months. First she helped Mrs. B buy wisely. Gradually, as the mother became surer of herself, the homemaker helped her learn more and more about running her household efficiently. This progress was made in an atmosphere of quiet and restfulness for Mrs. B and of orderliness in the home.

Meanwhile, the husband and wife were using the services of the caseworker. She helped them to work out a long-standing marital difficulty and to learn about child care. She also arranged for the husband to get the vocational training he had wanted for a long time. He said one day that they were better off as a family than at any time so far in their marriage.

HOMEMAKER SERVICE is usually provided by privately supported family service associations or children's agencies, and recently by a few departments of public welfare. It is an integral part of the agency's program.

These agencies are a logical setting for homemaker service because the principle of casework is to help persons individually in the way that will best solve their problems. Casework agencies build their programs so that they can offer a variety of services to meet various needs of the persons who come to them for help. But they also help these people to use agencies in other fields that offer services they need. For example, many clients of casework agencies have medical problems. They may or may not realize this. The caseworker will help the client to think about measures to keep himself in good health. Together they can plan what is best for him to do about medical attention. The worker knows the sources of health or medical services in the community just as she knows where persons can get other kinds of service. Casework follows no one pattern of help; it uses and suggests many sources for it.

It is true that homemakers are needed by agencies other than family and children's agencies and by individuals who have no connection with any agency. Ideally, the casework agency should have (and wants to have) enough homemakers to meet all fitting requests for them. Adequacy of staff is a matter of community support.

There is much more to a program providing homemaker service than the daily work of the homemaker. This "much more" (excepting general administration) calls for casework knowledge and skills. It begins quite a while before a reassuring, capable woman walks into a home in which something unusual and perhaps disturbing is happening.

First, women who are suited to this work must be selected and trained. Part of the training for each woman is learning just what her duties are and what advisory support the caseworker will give her in carrying them out.

Second, when a family asks for service, a caseworker helps them to decide whether this service is the most suitable for their situation and if it is, whether they want to use it. The caseworker should feel reasonably sure that they can use it to advantage. Skill at this point—at intake—helps ensure success by applying the service to appropriate situations only.

Third, when the service starts, the caseworker helps the family get the most out of it. Otherwise, some of its values might be lost to them. A caseworker can help in many ways to make the time the homemaker is assigned to a family more beneficial to them. Sometimes the need for help with personal problems becomes evident during the service because the parents recognize the caseworker

as a source of advice about these difficulties.

The homemaker, too, needs, the caseworker. She needs support and practical suggestions from her supervisor who understands the interplay of human relations and is able to see the family situation in perspective.

A homemaker often is assigned to a family whose situation is discouraging or depressing. She needs help to see it objectively so that she will not be too much disturbed by it. She may need a reminder that solution of the underlying problems must be reached by the family itself, with a different kind of assistance from that she can give.

In fact, what not to do is one of the decisions the caseworker and the homemaker have to make. Going into a home when there is tension, and taking over the mother's duties without in any way taking her place is a delicate piece of work. For example, when the mother is not a good housekeeper or does not understand child care, deciding how much to do for the children's good, but what to leave undone for the mother's peace of mind when she returns is a fine point. But on such decisions the usefulness of the service depends.

HOMEMAKER SERVICE IS relatively limited in coverage. The current directory of agencies employing homemakers, issued by the Children's Bureau in cooperation with the National Committee on Homemaker Service, shows that of 72 agencies reporting about their services in March 1949, 66 were in the United States, 1 in Puerto Rico, and 5 in Canada. The agencies are located in 22 states, the District of Columbia, and Puerto Rico, and in 3 Canadian provinces.

But in no place is the service sufficient to meet the demands for it. Services now functioning should be strengthened and expanded; new programs should be developed in many places. Most services are in big cities and in the Eastern states. Only small beginnings have been made in a few rural areas.

However, state, county, and city departments of welfare are now showing a highly encouraging interest in this service. The service fits very usefully into the program of public welfare as a whole, which includes services to children in their own homes whether or not the family is in economic need, and aid to dependent children.

WHEN HOMEMAKER SERVICE exists in a community, the backing of public health nursing organizations is most necessary for its success. The visiting nurse, the caseworker, and the homemaker often work together in a family where there is illness. Nurses see on their calls which families need such a service and, afterward, whether they have benefited from it.

Nursing knowledge and experience make representatives of nursing agencies valuable members of committees interested in studying or starting homemaker service and of committees of agencies that employ homemakers. For instance, a public health nurse can give practical help to a committee that is differentiating betwen the duties of the graduate nurse, the practical nurse, and the homemaker.

The people of some communities, and even the local social and health agencies, may not understand why this service is provided by a family or children's agency or a public welfare department rather than by a health agency. They may think of the homemaker as a practical nurse. Nurses are in a good position to explain the reason for sponsorship by a social agency and to explain what a homemaker does.

Nursing agencies can help physicians to understand the usefulness of the service. Sometimes when a homemaker is assigned to a family where there is illness the doctor does not appreciate what the homemaker is to do. He may expect her to do things for the patient that are beyond her skill. When doctors fully understand the homemaker service they can be exceedingly helpful. They can request the service for families who need it most and can recommend wisely how long it need continue. However, doctors, nursing agencies, and hospitals should remember that a family in need of a homemaker may not want one. Under these circumstances, the placement is not made.

When no service exists in a community, the public health agency usually realizes first and most deeply the need for it. That agency's

voice must be heard and its energy exerted if a service is to be established.

The idea for a service in Madison, Wisconsin, for instance, began with the visiting nurse association. The association's board of directors became concerned about the amount of nursing time that VNA nurses had to spend on housekeeping service to the chronically ill and the aged. The service was necessary but was not part of a nurse's duty. The nurses, the board also saw, were frequently asked to arrange for the care of children when their mother was ill or at the time of her confinement—also clearly not a part of their duties.

The "unmet need" was referred to the Health and Planning Council of the Community Chest. That council appointed a committee, broadly representative, to look into the matter. The committee studied reports of services in other cities and asked for opinions on the need of such a service in Madison from physicians, medical social workers, clergymen, school officials, and others.

After six months of work the committee agreed that homemaker service was needed and, in this community, belonged in the family service association. That agency sought advice from the family service agency in Milwaukee, which has given homemaker service for some time.

At the end of a year of planning, a conference on administrative details was held with a representative of the state department of public welfare and of the Children's Bureau of the Federal Security Agency. Two months later, after 15 months of preparation, the program was in operation. The committee had moved slowly in order to keep all the groups concerned fully informed and interested at all stages.

The experience in Madison shows health and social agencies acting together to bring a service into being. That kind of coordinated action must take place at all levels of administration if we are to get, within a reasonable time, enough homemakers to serve the mothers who need them at the time of confinement.

Joint planning by the state department of health and of welfare is necessary if these departments are to be ready to advise local agencies that want to start, expand, or strengthen homemaker services.

But it is in the counties and cities that the spark of imagination about getting under way must be struck and the elbow grease of hard organizing work must be applied. There the public health nursing agency and the social casework agency must work together, each one shouldering the responsibility that its skill marks out for it. This true coalition of the two professional strengths will help the service grow to full stature.

The Children's Bureau can supply additional information on homemaker service on request, free of charge. Children's Bureau, Federal Security Agency, Washington 25, D. C.

It Worked In . . .

An exchange of successful public relations projects

Westchester County, N. Y.—An outstanding example of coordinated planning for building sound public relations is *The Link*, a bulletin of the Westchester Nursing Council. A recent issue contains besides the bylaws, standard personnel policies, directory of officers, committees, and meetings of the council, a map which shows at a glance where all voluntary agencies and agencies with combination services are located, and what areas lack the services of a voluntary agency.

In a summary, immediate, county-wide problems are succinctly stated and possible steps toward solving them outlined.

Pertinent information for each of the 16-member visiting nurse associations includes: address, telephone, office hours, territory covered, type of service, number on staff, retirement provisions, and a short history. A special section is devoted to a list of officers and delegates of member agencies.

Another, and particularly useful, section is devoted to data concerning the county health department and the various city health departments.

The format of *The Link* provides for the insertion of new pages from time to time. Lists of newly elected officers and delegates will be issued each year, and special pages with the latest news on public health agency programs and developments will be issued several times during the year.

Copies may be obtained for $1 by writing the Westchester Nursing Council at 709 County Office Building, White Plains, N. Y.

The council president, who had served in the State Federation of Women's Clubs as department head and committee chairman, felt that the Westchester County clubs could help interpret public health nursing in their various communities. So one of the federation's radio programs was obtained for telling the story of visiting nursing and relating it to women's clubs.

Following this, bonds were further cemented by obtaining the New Rochelle Woman's Club house for the annual meeting of the council to be held this month. All Westchester women's clubs, PTA's, et cetera, were asked to send representatives, and the program was planned to interest public spirited women (potential board members) in one of the great problems of the day—geriatrics. Notices of the meeting were inserted in all club magazines.

Everytown—"Don't overwhelm the reporter with abstruse data going back to the founding of the agency or the basic philosophy of social work," advises A. H. Raskin, labor correspondent for *The New York Times*, in a recent issue of *Better Times*. Two other warnings he gives are:

"Nothing builds up more lasting ill will than efforts at censorship or advice on how the story should be written."

"Pettifogging insistence on technical minutiae comes only slightly behind these in any reporter's list of pet hates."

Jackson, Miss.—County nurses in Mississippi have found the "flannel board" an effective means of illustrating demonstrations and talks. It is made by covering a light-weight board with outing flannel. Paper cutouts mounted on flannel can be placed on the board as the speaker wishes. They stick because

flannel sticks to flannel, but can be easily removed or moved about.

Oakland, Calif.—PTA representatives, school teachers, principals, and nurses became concerned last fall over the number of children coming to school in the morning without breakfast. A Better Breakfast Campaign was undertaken to convince both parents and children of the importance of this first meal of the day and to demonstrate how nutritious and appetizing breakfasts can be served at low cost.

Students in two schools prepared and served model breakfasts. Thirteen other schools planned and distributed sample breakfast menus, set up classroom projects in nutrition, spoke to PTA meetings and sent special letters to parents on the importance of nourishing breakfasts.

Pittsfield, Mass.—For three years the Visiting Nurse Association of Pittsfield, Massachusetts, has been telling its community in weekly 5-minute broadcasts over a local station how the public health nurses can help them to get and keep well.

Subjects which proved especially popular were: how to keep well in hot weather; equipment available through the loan closet and how it could be used; care of the new baby and of the young child; and how to avoid respiratory infection.

Mrs. Philip A. Damon, a board member who writes the scripts, has been rewarded by countless voluntarily offered testimonials from fellow townspeople.

One week one of the engineers came out of the control room just after the broadcast to say that his wife would be glad to hear about the classes for expectant mothers. Later he gratefully reported a Class A first arrival.

Once Mrs. Damon stopped on the way home from the radio station to have her shoes shined and heard two other patrons telling how much they'd enjoyed the broadcast. Another time she took a taxi home, and was told by the driver that he'd heard about the bedside nursing service through her program just at the time he and his wife were in despair about how to persuade his diabetic mother to follow the doctor's orders. The public health nurse had not only solved the immediate problem; she'd unobtrusively managed to help smooth out family unhappiness.

It's safe to say Pittsfield is one town that appreciates its VNA.

—H.N.

Mental Health

(Continued from page 258)

everyday living as being evidence of illness or the abnormal. We forget that there is a wide range of normal, and it is the differences in people which make them interesting. We are inclined to make diagnoses of our friends' personalities because they are different from us. Someone has said that the things which we dislike in other people we will find in ourselves, if we look closely.

Nurses have always found themselves in the role of the comforter. The doctor sees a patient for brief periods and often leaves him with worries and fears which although without foundation are there, nevertheless. It remains for the nurse to quiet the fears, to reassure the patient, and help him to maintain his emotional stability. Nurses have performed very well in this role as they have in many others. However, I think that there is a definite challenge in this field. To be sure, it may add to the nurse's work in some ways, but it also makes her work easier and more enjoyable.

Living itself is a matter of give and take and is based on human relationships. If we can base our relationships on mutual understanding and respect for the other fellow, we will all live happier lives.

Presented at Arizona State Nurses' Association Convention.

ANSWERING PARENTS' QUESTIONS ABOUT CHILDREN'S TEETH

CHARLES A. LEVINSON, D.M.D.

THE ANNOUNCEMENT of the American Dental Association and other dental societies, recommending the fluoride treatment for children, is good news to everyone concerned with saving children's teeth. It has been discovered that swabbing a 2 percent solution of sodium fluoride on the teeth of children at the ages of three, seven, ten, and thirteen will result in the reduction of tooth decay by 40 percent.

Recently I received a communication from Dr. John W. Knutson, USPHS, one of the co-discoverers of this efficacious fluorine treatment, who wrote that the age limit for effective fluorine treatment has been increased to seventeen years. Now that children can be protected to an extent against dental caries it is every parent's duty to see that his children are given this advantage.

A caution should be observed, however. The chemical should be administered only by a dentist or by a qualified dental hygienist, because sodium fluoride is a deadly poison and must be used carefully.

The treatment is simple. The dentist cleans the teeth, dries them thoroughly, and applies the solution. Children are given a series of four treatments a year, at the recommended age intervals, so that all the teeth will be treated shortly after they appear. However, immunity to decay is not to be expected merely from treatment with the drug. The topical application of sodium fluoride, as it is known technically, does not prevent all tooth decay. It is only a partial preventive.

Parents are warned against the use of commercial preparations — tablets, dentifrices, mouth washes, or chewing gum—containing fluorides. None of these preparations which are offered to the public every day have been approved by the ADA up to the time this was written. Experiments are in progress to determine the value of adding small amounts of sodium fluoride to drinking water. Where fluorine is contained in the drinking water, tooth decay is less than in other areas.

Recently a group of dental scientists and others doing research work at the University of Illinois College of Dentistry developed a combination of dibasic ammonium phosphate and urea (carbamide) which may be purchased in the form of tooth powder or tooth paste at drug counters. Known as the ammoniated or ammonium ion dentifrice, it generates ammonia when moistened, and because ammonia kills bacteria and neutralizes mouth acids its discoverers claim it will prevent tooth decay. This discovery, still in an experimental stage, has been accepted only for clinical trial purposes by the ADA. Believing that the dentifrice may have some valuable effects, the association has not discouraged the public from using ammoniated preparations. However, final judgment is still withheld.

Therefore, it is as safe to use these ammoniated dentifrices as it is to use any ordinary tooth paste or tooth powder, but don't expect them to perform miracles. Time will

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tell whether they have staple remedial value as tooth decay preventives. However, in using these ammoniated dentifrices, unlike the common dentifrices, the mouth should *not be rinsed* after brushing the teeth. Rinsing destroys their value. The preparations should be used immediately after eating—especially if the meal has consisted of many carbohydrates. These dentifrices may be used by children as well as adults.

Despite these two recent dental discoveries, we must not forget that the two most important factors in the salvation of children's teeth remain two very old reliable health standards —good nutrition and proper mouth hygiene, both of which play the most important part in producing sound teeth and healthy gums.

CHILDREN'S TEETH AND JAWBONES are made hard and sound by the formation of calcium and phosphorus, minerals found in foods like milk, cheese, citrus fruits, and certain vegetables. Foods rich in vitamins aid the teeth, jawbones, and gums, also. The starches and carbohydrates, the carbonated beverages, and the second helpings of dessert, which American children indulge in, do not help to achieve sound teeth and healthy gums.

Children must be taught to eat slowly, to masticate their food well, and to chew on both sides of the jaw simultaneously in order to avoid malformed jaws. Watch out for bits of hard or sticky candy left between the teeth, as these foster the growth of bacteria. Pure milk chocolate is best for children if they must have sweets. This should be given at the end of a meal and teeth should be brushed immediately thereafter.

Children should be taught to brush their teeth five times a day: before and after breakfast, after lunch, after supper, and before retiring. The function of the toothbrush as an aid to keeping the mouth clean is definitely recognized in preventing tooth decay. Next to diet it has an important role in promoting good dental health.

In teaching correct toothbrushing, make certain that the back teeth as well as the front teeth are thoroughly brushed. Children have a habit of skipping the posterior or back teeth. Use cold water for tooth brushing—never warm.

Youngsters should have a soft toothbrush with three or four rows of bristles. I prefer the natural toothbrush bristle, commonly known as the natural hog type bristle. It may be obtained at any drugstore. These natural toothbrush bristles are better for the mouth, and do a more thorough cleansing toothbrushing job. The bristles always should be firm and straight. Toothbrushes should be changed every four or six months —sooner if the bristles are bending out of shape.

Children should be taught to spend at least three minutes at each brushing, or they derive no benefit from it. This time includes gum massage, mouth washing, and brushing of the tongue. A great many methods are advocated for brushing children's teeth. The family dentist may suggest a reliable one. However, good, vigorous brushing is the most important factor.

When a child starts to brush his own teeth be sure that he can see himself in the bathroom mirror. He will learn quickly with someone standing behind him and guiding his hand. It is much better to encourage a youngster to clean his own teeth than to do it for him to assure it being well done.

At the age of two, children should be taken to the dentist for an examination. This should be followed by regular visits at least every four months until the child is twelve when the visits may be spaced at semi-annual periods. This routine should be carried out through life.

There is a great campaign to save children's teeth. Parents must do their share in this. All together—parents, teachers, family dentists, and public health personnel—will one day accomplish their goal of conquering a health menace of our times, tooth decay.

REGIONAL CONFERENCES

PROCEEDINGS OF THE recently held NOPHN regional meetings in Richmond and Indianapolis will shortly be mailed to the participants. Others may purchase copies for one dollar each. The following highlights have been abstracted from the summaries given at the final sessions by Miss Hubbard in Virginia and Miss Fillmore in Indiana.

Both speakers referred to the splendid preparation made by the local committees and expressed gratitude for the comfortable arrangements and the pleasant periods of recreation. At each conference there were special sessions for nurses interested in tuberculosis, in school nursing, for board and committee members, and for public health nursing administrators and educators. Following are some of the points discussed:

Our declared purpose in coming together for these NOPHN regional conferences has been to share the points of view of board members, administrators, supervisors, and educators on current problems in planning for community public health nursing services. It is our hope that we have all gained a better understanding of current day-to-day needs and also have received some direction for planning together for improved public health nursing services.

It seems we have displayed a growing maturity in our approach to our work. We have accepted changes in patterns, in treatment, and evaluation technics. We are less self-conscious. There has been less discussion of the retention of identity or of programs in which we alone are needed. Understanding, relationship, and that somewhat harried word, *teamwork,* have been heard repeatedly in the various sessions. We realize public health nurses are one of several groups of workers; we have respect for other groups, and a justifiable pride in the "something" we have to contribute.

There were certain threads running through the discussions. It was the unanimous opinion that public health nursing is expanding and changing in many ways. Of course this is not a new idea. The points were made that we need to think more about planning for immediate as well as long-term programs; we need to be selective and evaluate what we do. Because we cannot give total service, the service we do give must be better.

There was agreement that programs can not be established by a regional or national group that could be followed by every agency in its local community. After agreement has been reached on what is good in general, each one has to adapt for herself those things which best will help the individual agency to do its job.

Another thread in the discussion concerned the public health nurse as a member of a team. Dr. Phillip Reed, the guest speaker at Indianapolis, talked of "togetherness." The public health nurse is a member of several teams, those composed of other professional workers, of other citizens, and of other nurses, including practical nurses. There was considerable interest in the subject of the practical nurse. Agencies employing practical nurses have not found this a way of lowering costs. What the practical nurse does is to free the public health nurse to carry on the work which only she can do. The practical nurse works best when assigned as a teammate of the public health nurse who continues to be responsible for counseling the family

and planning the patient's care. Assignments should not be made on the basis of type of case, such as, an elderly patient or one with a long-term illness.

In general, public health nurses need orientation to work effectively with practical nurses, and agencies using practical nurses should assume responsibility for this aspect of staff education.

All the special groups held interesting discussions. Some of the conclusions follow.

BOARD AND COMMITTEE MEMBERS

Those participating in the board and committee members discussions agreed (1) that it is a sound plan for boards and committees to secure representation of all points of view and of special interests so that the group honestly represents its constituents (2) that the nominating committee has a vital full-time job, since this committee may well be responsible for either weakening or strengthening the board. The committee should have criteria for the selection of new members. Nominees need not always be members of other boards and organizations. Some agencies find individual memberships one way of preparing people for community participation. Agencies have a responsibility for keeping such members informed (3) that when board meetings fulfill their function—that is, the transaction of the organization's business and provide an opportunity for study and development—those meetings will be interesting. The executive director's report should stimulate discussion. Adequate time should be allowed for this and for discussion of other committee reports (4) that the problem of finances is always present. There is much interest in developing all possible sources of income. In a number of places where collection of fees appears to be a real problem there seems to be a reluctance on the part of the staff to accept the philosophy that charges can be set and interpreted on a cost basis. There is recognition that community chests and community agencies must plan together and that board members have an important contribution to make in this planning together (5) that there should be a planned program for the introduction of new board members for which the board members take responsibility and participate in (6) that every public health nursing agency should have a year-round public relations program with clear-cut objectives. There is still a need to interpret available services to communities (7) that community chest campaigns usually do better when agency board members take part in the drive but it is necessary to make sure the board members are properly trained to solicit contributions.

SCHOOL NURSING

The discussion in these groups centered around these major points (1) that the objective of the nurse in school regardless under what type of administration (health department, board of education, visiting nurse association) she may be working, is the same (2) that the relationship of the school nurse to the school administrator presents problems and questions regardless of what group employs her, as school nurses have a community of interests and concerns which crosses administrative lines (3) that the objective of teaching parents and the child the value of health supervision and health practices is best reached when the parents take the child to their own physician. This permits continuity of medical supervision. Obviously this service is improved when the school findings are transferred to the doctor and when his findings are reported back to the school health personnel (4) that when the nurse in school has limited available time, this is best spent in demonstrations and conferences with the teacher centered on the needs of the children. The teacher is then better prepared to carry forward the health program more soundly (5) that there is too little pre-service preparation of the teacher in school health programs and that nurses might contribute to improving this situation by (a) offering to participate in discussions and demonstrations at local teachers' colleges and (b) that school nurses as a group work with teachers to interest state boards of education to provide all teachers with the preparation in health services now given those preparing for work in home economics and in kindergarten programs (6) that the school health council

is important in planning for good school health programs. The council must be closely correlated with the community health council (7) that the nurse is not prepared to do classroom teaching. She can contribute from her special knowledge to teachers and to curriculum committees.

ADMINISTRATORS AND EDUCATORS

This group undertook to do realistic planning for public health nursing to families. Some points were discussed in detail but it was soon evident time was all too brief to follow this method with all the challenging matters on the agenda. The following agreements were reached (1) the objective of public health nursing continues to be the development of good health in the families in the community (2) the services of public health nurses are developed around the four basic functions of the public health nurse (a) care of the sick in their homes (b) rehabilitation (c) promotion of healthful living (d) prevention and control of disease (3) criteria for a balanced program in public health nursing are (a) examination of vital statistics, morbidity, population trends, socio-economic factors as aids in determining the relative importance of problems (b) examination of the present program in relation to the problems thus revealed (c) determination of the actual readiness of the community for service—lay, medical, and other professions (d) examination of changes in medical practices and the effect of this upon the nursing program (e) survey of the community for its ability to provide staff and facilities for a balanced program (f) determination of the help needed by the staff to give this balanced program—staff education (g) examination of our own work in relation to the work of other disciplines and citizen groups in order to determine our appropriate place in the community health program (h) evaluation at appropriate intervals (4) there is no one pattern for developing community services or for their administration. The unique contribution of the voluntary agency is the participation of a responsible citizen group and whatever new designs may be proposed for public health nursing this type of citizen activity should be preserved and strengthened.

The group concerned with education had a productive discussion centering around the joint responsibilities of the university and the agency in preparing the public health nurse of tomorrow. The familiar phrases, orientation, in-service staff education, inter-agency staff education, field instruction, were frequently heard. One was aware of the rapidly emerging pattern of team work—the team being composed of field staff, supervisors, educators, and personnel from the universities and health or nursing councils.

At the general session in Richmond Dr. William H. Kelly, director of the Richmond Memorial Guidance Clinic, was the guest speaker. Dr. Kelly spoke of the place the nurse in a public health nursing program has in understanding the individual and his reaction to a situation. If she can do this and develop a wise use of her own professional self, acknowledging limitations honestly, we need not fear for her contribution.

TUBERCULOSIS NURSING

The groups reached five conclusions in their discussion (1) that a sound knowledge of epidemiology is important for a nurse in this service since programs and the care of individual patients are based on this information (2) that priorities for case loads and visits need to be established. The special service must be correlated with the special needs and services of the whole community (3) that the nurse has an important place on the team which plans for x-ray surveys, but one of her most important functions is in the follow-up period (4) that the means test can be a severe handicap to a patient with a long-term illness, such as tuberculosis (5) that a good program in any specialty calls for sound community organization and community planning.

At these conferences, the newly revised, 1950 edition of NTA's "Diagnostic Standards" was discussed by a nursing group for the first time. The terms, "arrested" "apparently cured," are being dropped in favor of "inactive." Watch for this report as well as Jean South's "Tuberculosis Handbook for

(Continued on page 297)

Congresswoman Frances P. Bolton meets the group.

Wide World Photos, Inc.

One Hundred KIDS and a NURSE

ELVA H. EVANS, R.N.

I LOVE A PARADE!

I loved a parade when as a youngster in white pinafore and blue bows, clutching a limp bouquet in one hand, and a small flag in the other, the line of march ended at the cemetery for Memorial Services.

But the parade I love most of all, from today's nurse-eye-view, is the national school safety parade held each May, in Washington, D. C.

The third year I was assigned to accompany the children, the excursion to the annual Washington rally seemed routine. Just another bus trip with 100 or so children—the parade, sightseeing, the motion sickness, herding them through minor catastrophes, and the major excitement of seeing celebrated people and places. But the morning the youngsters stood grouped around the buses the undercurrent of eagerness for the adventure to begin was contagious.

They were all well-behaved, these school safety patrol members whose service had earned the reward of a 4-day trip to Washington to attend the National Safety Rally. But the solemnity of their expressions as they queued up for the preliminary examinations was a transparent mask for the animation and eagerness for the adventure ahead, and the fear of being denied at the last moment.

Our group of 106 patrol members from northeastern Ohio was sponsored by the Cleveland Automobile Club. We were one of the many groups who represented 460,166 safety patrol members from more than 6,000 communities who would attend the 1949 rally. One of the unique features of our group was

Mrs. Evans is executive secretary of the Cleveland Council on Community Nursing.

the presence of a nurse on the staff accompanying the children. At the 1947 rally, the first held since VJ Day, public announcement was made of this fact as we passed the reviewing stand. This year at least one other nurse was observed and several Red Cross uniforms were in evidence.

From the point of view of the nurse, preparation for the trip is not too difficult. Precautions are taken that only children in good health are chosen. Each candidate must present a doctor's or nurse's certificate of examination issued within three days of departure. Of 106 health forms this year, 70 had been signed by school nurses and 36 by school doctors. Waivers are signed by all parents.

BEFORE BOARDING the bus, each youngster presents his health certificate to the nurse and is given another examination. She inspects the oral mucosa and pharynx with the aid of a flashlight and tongue depressor. The area over the upper chest is checked and the cervicals palpated for enlarged lymph nodes. The palms of the hands are felt for extreme dryness or moisture. Most frequently, moist palms are merely a symptom of suppressed excitement and anticipation rather than illness. If there is any suspicion of sore throat or other infection, temperature and pulse are taken, recorded, and the parents or guardians who accompany the children to the depot are consulted. In three years, the physical condition of only two children was doubtful, but in each case papers were in order and parents agreed to the child's immediate return should symptoms persist.

One youngster whose fitness was questioned had a history of rheumatic fever. However, the nurse was reassured that it was safe for him to make the trip. Nevertheless, the day before the parade he developed a two-degree elevation of temperature and complained of not feeling well. Not wishing to deprive him entirely of the pleasure of participation in the climactic parade, when his temperature dropped to nearly normal and remained there, we made arrangements for him to ride in the lead car with the two state highway patrolmen who accompanied us. Most likely, all that was wrong was too much excitement, for no complications appeared then or later.

On the other hand, one boy who was perfectly normal at the outset of the trip presented a nursing problem after we had arrived in Washington. The night following the parade, one young fellow informed the nurse that his roommate refused to come to the dining room for his meal. We went up to his room and discovered a very sleepy, feverish boy. He wasn't hungry, he didn't have any pain; he just wanted to sleep. He was specialed all night. Though his temperature dropped after he'd emptied his stomach, it did not return to normal. On the return trip, he rode in one of the private cars and was watched. Except for the slight elevation of temperature, nothing much seemed wrong. But about the middle of the following week, he was ill with a mild case of measles from which he recovered in record time.

Unfortunately, not all the incidents of illness end so simply or happily. One lad of nine was permitted by his parents, the school physician, and nurse to make the trip. His credentials could not be ignored by the nurse counselor, particularly because the child's temperature was normal and there were no contraindications, other than a small tumor-like mass on the lower left border of the mandible. The boy was immature for a nine-year-old; he had not learned much self-discipline and was the only child ever to become lost. His own intelligence and identification badge made his return simple. However, his health was a greater problem. He gained little by his journey, becoming seriously ill and requiring special care by the nurse or another counselor. He further complicated matters by responding only to the nurse and one other counselor.

These incidents serve as a measure of the planning and combined effort required of the nurse and counselors who annually accompany the 100 or more 10-15-year-olds. Our caravan included three buses, a dual control passenger car, and a state highway patrol car. The personnel included, besides the nurse, six counselors (four teachers and two police officers), one newspaper woman, and two highway patrolmen. Preliminary to the journey, a conference is held. A list of

instructions is drawn up and the bus company and automobile club collaborate on planning a route. Some of the instructions include:

Car sickness. Review car sickness with the children. Explain that there is nothing to be ashamed of. If they will let you know as soon as possible *before* getting sick several things can be done:

1. The nurse can be called. She will be riding in the passenger car behind, unless busy in one of the buses. Merely have your driver pull over to the shoulder of the highway and stop. The passenger car will stop to see what is needed and transfer the nurse to your bus if someone is ill.

2. Sometimes it is sufficient to have a child who feels nauseated stand in the front of the bus and look straight ahead at the road. Warn the children if the worst comes to the worst, to use the bags provided or the sand pail. Explain that it is much better to follow these instructions than to have an accident which may result in others getting ill.

Assistance. The children should feel free to call the nurse, at any time, *day or night,* if they need anything. The hotel desk will always know where to reach her.

The first *comfort stop* will be . . . .

There is food on your bus to distribute. After leaving the comfort stop you may give the children the sandwiches, milk, and fruit that are on board. Use your own judgment regarding how much you pass out and when. You may distribute cookies or whatever is left of breakfast as a snack later in the morning if you think it advisable. There will also be gum and hard candy for you to hand out at your discretion. On the way back a supper snack will be put on board when we stop for dinner.

You will find a blanket, straws for the milk, aspergum, paper cups, and bags for accidents on board. We suggest you locate these supplies, and place them in the bus where they will be convenient.

Please try to control the hot dogs, cokes, et cetera, your children buy from vendors between meals.

Routes selected are wide and have few curves. Winding roads contribute to motion sickness and cause almost as much trouble as indiscriminate eating and fatigue. En-route, the nurse carries a first aid kit and rides either in one of the cars or buses. A system of signals is agreed upon between the vehicles so that they all stop should the nurse be needed in another bus.

ASIDE FROM THE children eating too much, motion sickness is one of the greatest trials on the road. A number of anti-histamines and the age-old Mother Sill's Seasick Remedy are brought along by the children. One youngster with a history of motion sickness brought along a supply of dramamine, one of the anti-histamines, which he shared with the others. All was well on the trip to Washington. On the return journey, the bottle was left in his suitcase and locked into the luggage compartment under the bus. The youngster had to be literally bathed with his clothes on under a faucet in a wayside gas station, then wrapped in a blanket until he dried out.

Despite the efficacy of modern drugs, we find it useful to take aboard plenty of chewing gum and hard candies. Distribution is left to the discretion of the counselors who use it to entertain and to reduce fatigue and motion sickness.

In Washington the nurse's duties vary. The first aid equipment is carried by the nurse, and the children avail themselves of her services beyond the hours scheduled as "check periods." Excitement and fatigue are the causes of most elevations of temperature, headaches, and stomach upsets. Occasionally, some youngster develops a cold or an acute case of homesickness. However, on the whole, nurses and counselors are mostly kept busy with hall patrol duty, checking on "set-ups" for informal parties and other premature sophisticated notions.

One of the greatest rewards of the trip is sightseeing in Washington through the eyes of the children, many of whom are away from home for the first time. The delight and wonder in their faces and voices would renew the interest and enthusiasm of the oldest, most tired visitor to the capital. Their simple and naive comments are often poetically ex-

pressive. One little fellow glimpsed a crystal chandelier through an open doorway in the White House. In a hushed, awed undertone he exclaimed, "Lookit. . . diamonds." And when we moved into the East Room and he saw the total splendor of the chandeliers and their myriad reflections, he whispered breathlessly, "Jeeze, there are three of them!"

And, of course, visiting the FBI enthralls the group—the greatest majority of whom are boys—more than the Lincoln Memorial, Washington's Monument, and most of the other sights combined. It is also exciting to meet the celebrities—senators, representatives and admirals. A chosen few have met with the President.

The Saturday morning parade is a high spot of the trek. Every child participates. Those for whom the long march is considered a hazard, ride. All Ohio marchers wear white "tee" shirts with a triple "A" monogram, dark skirts or trousers, yellow Sam Browne belts with metal badges, and blue garrison caps bearing the legend "Cleveland Auto Club AAA, Cleveland Safety Patrol." The whole show is a treat with its baton-twirling majorettes, bands, floats, and awards.

Aside from the mere accompaniment of a group of school children to a rally, this experience has other significance for the school nurse. There is no doubt that nurses have contributed through the years to school safety. More nurses might cooperate by including patrol interest in their over-all plan for health teaching and nursing service to school children. More nursing service could be added to the services given by the automobile club personnel, school administrators, and teachers, police and safety officers, and public-spirited citizens. The school safety patrol movement nurtured by the American Automobile Association has built a fine record. Better citizens, more lives saved, fewer accidents and injuries are written into the record. In the last 30 years the death rate for 5-14-year-olds has been reduced 27 percent. In the same period of time, the rate for the whole population has increased 61 percent.

Too many do not regard safety patrol activity as a health activity. Even nurses may be hard pressed to define any nurse responsibility in safety activity. How many nurses include the safety patrol in health lessons? How many nurses, like some school officials, take the safety patrol for granted while waving the flag for athletic events? By encouraging and cooperating with the school safety squads, many nurses in schools may find a new activity that will reward them with extended horizons.

Regional Conferences

(Continued from page 293)

Public Health Nurses" which should be ready shortly.

CONCLUSION

We realize anew the importance of doing our own work and doing it well. Parenthetically, we may need to identify our own, and as we realize the importance of doing our own work, we come to accept and acknowledge the limits of that work so that we do not attempt to be "all things to all men."

The recognition of these things in each group showed a keen awareness for the need of research in all phases of our work. To evaluate our progress during the first half of the Twentieth Century we measure our success by the distance we have traveled toward the goal, and at the dawn of 1950, we can honestly say that the American family accepts greater responsibility for its own health than it did in 1900.

TRENDS IN MEDICINE AND PUBLIC HEALTH

SOCIAL FACTORS IN OBSTETRICS

"Efficient childbearing will be influenced by many factors, but none so much as the mother herself. The mother is the product of heredity and environment, and therefore so far as possible the whole woman should be studied. We wish to know something of her basic intelligence, her personality, and her home background. We wish to know how she spends her money and what kind of housewife she is, what kind of food she eats, and what she thinks about childbirth and the rearing of children. We can then study how she behaves during pregnancy, labor, and lactation, not only in a first pregnancy but also in subsequent ones. In this way we may be able to build up a picture of various types and discover what psychological, social, and physical influences affect reproductive performance and how they act.

"Social-medicine research in childbearing offers some peculiar advantages. The fact of pregnancy offers a ready introduction to the patient, and usually ensures cooperation, especially when it is obvious to the patient that definite advantages accrue from cooperation. Also, the effect of the various social factors can be assessed against a definite yardstick—reproductive performance."

" . . . the highest grade of efficiency means high fertility, very good health, and a sense of well-being during pregnancy, freedom from any of the recognized complications, spontaneous delivery of a live and vigorous child, normal involution, and successful lactation. How far short of this standard any particular person may fall, and why, is very difficult to determine accurately. For example, how much significance is to be attached to vomiting during pregnancy, and how far is the length of labor an index of efficiency during labor? In view of these difficulties it is understandable that in the past reliance has been placed largely on mortality figures, and up to a point this is justifiable. Thus it is now well recognized that mortality in the first twelve months of life is a most delicate index of living conditions, but in dealing with reproductive performance mortality is less helpful and sometimes misleading."

—Excerpts from an article by Professor Dugald Baird, *The Lancet*, June 25, 1949, in which he also makes a statistical comparison and analysis of a group of English primiparae and primigravidae according to height, age, and social class.

ATTITUDE OF VD PATIENTS

So that they will return for necessary diagnosis and treatment, and recommend the facilities to others, it is necessary that venereal disease patients have a favorable attitude toward the clinics and rapid treatment centers they attend. To determine the patients' attitudes and evaluate the services of the clinic and centers, a study was made by Lida J. Usilton and John W. Morse. The report covers 1,700 persons in clinics and rapid treatment centers in 7 states.

The results show that the attitudes of persons served in clinics and treatment centers do have some indirect bearing on the venereal disease case finding program since word-of-mouth advice was an important factor in getting infected persons to seek diagnosis. Only 8.5 percent of the persons attending the clinics and 4 percent of the treatment center patients, when questioned, said they would not recommend the clinic to persons who needed an examination for venereal disease.

In general, the attitudes of patients toward both clinics and treatment centers are quite favorable, though there were large differences

in the attitudes of persons from clinic to clinic and among treatment centers. In the distribution of age groups, those under 20 years of age, the group in which syphilis is more prevalent, were found to be about four times as dissatisfied with both clinics and centers as those patients over 40 years of age.

Patients expressed criticism about personnel and other patients, about long waiting in clinics, lack of privacy, inconvenient clinic hours, painful treatment and lack of information about their diagnoses and treatment.

A suggestion box might be useful in securing comments from patients in other types of clinics, since such information will provide grounds upon which action may be taken.

The complete study appears in the *Journal of Venereal Disease Information* of the USPHS, October 1949.

JUVENILE DIABETES

Discussing the "Free vs. Controlled Regime in Juvenile Diabetes," Dr. Priscilla White speaks strongly in favor of the controlled regime for juvenile diabetes. She reports on a special study of 380 patients whose diabetes started in childhood and who survived 20 or more years of the disease. She also reviews the recommendations concerning diet and insulin of the George F. Baker Clinic, New England Deaconess Hospital.

In infancy and after the age of seventeen, it is not difficult to enforce the controlled regime. Completely dependent, the infant affords no problem. However, between the ages of one and ten difficulties begin to arise. For a successfully controlled regime, an essential quality is a sense of timing—of diet, insulin, and exercise. The young child has no accurate sense of time. He putters, and time drives him. Other essentials are an appreciation of cause and effect relationship and an understanding of death. The last factor is a need for truthfulness about records and tests, diet, and the administration of insulin. Normally he aims to please by giving good reports. These more or less philosophical concepts are not developed to any extent until children reach the age of nine.

The adolescent, preoccupied with his need to fit into the pattern established by his contemporaries, often rejects the details of a controlled diabetic treatment. That 40 percent of all coma cases are made up of adolescents in the second decade is corroboration.

Boys between the ages of ten and twenty worry about their future careers; girls, about their possible future husbands. Diet breaking is a natural result of such depression. With understanding guidance, the adolescent's attitude by the time he is seventeen, is usually good.

In Dr. White's study, it was found that 93 percent of the 380 persons showed incidence of vascular disease. In this group, poor control of diabetes did parallel the frequency and severity of the vascular lesions.

To maintain the routine and the attitude of the infant patient, training of the parents is considered essential. Management of the child between the ages of one and ten should include, at the start of the treatment, hospitalization for training the patient and the parents, too. Self-administration of insulin is not recommended under the age of ten.

Yearly refresher courses and diabetic summer camps are also important. For the adolescent, group handling is most valuable. Contact with the members of the next generation who have experienced the same doubts and difficulties can be more useful to the diabetic adolescents, than can the help of their parents or physicians.

The report appears in the *Journal of the American Dietetic Association*, September 1949.

IMPROVING COMMUNITY MENTAL HEALTH THROUGH THE SCHOOLS

Many projects demonstrate how present and emerging knowledge of conditions which favor sound mental health may be applied within the framework of existing community programs. Through the collaboration between a mental health clinic in a county health department and a school system, an improved program of education and health services was achieved.

An examination at the clinic of one child, a slow reader, indicated the need for a preventive service which would help all

children with a similar problem. As a result of joint planning by the clinic and school personnel, a special summer project, making use of the classrooms which would have been vacant during vacation, was sponsored. Although the actual improvement in reading skills after 20 days was only slight, the change in attitudes toward school and reading was dramatic. These children now were *interested* in reading. Teachers in the regular sessions were helped to meet the children's special reading needs and some of them took study in this field. The summer remedial reading session was expanded and became a regular feature.

A study was also made of slow-learning children. The clinic personnel recommended that a special educational program be established to meet the needs of this group. Lack of funds prevented this, but it was decided to review the data about these children that had been already collected and see if certain changes in program and curricula could be carried out within the existing budget.

In studying teachers' reports, it was found that few (in one school, not any) teachers recommended correction of poor health factors in dealing with the slow-learning group. This, despite notations by the teacher that the children were malnourished and had visual, hearing, and speech defects. There were wide variations in the teachers' capacity to observe and care for special characteristics of the children in their classes.

The project is more fully discussed by Dr. Charles A. Ullmann in "A Public Health Approach to Improving Community Mental Health Through the Schools," *Public Health Reports* of the Federal Security Agency, December 30, 1949.

What a MIDCENTURY CONFERENCE can do:

- Focus attention on our concern for children and youth in a world in which spiritual values, democratic practice, and the dignity and worth of the individual are of first importance.
- Bring together, in usable form, our present knowledge about the status of children, their physical, mental, emotional, and moral development; and identify areas in which further knowledge is needed.
- Point up the needs of parents in providing adequately for their children and suggest ways of helping them do a better job.
- Look at the physical, social, economic, and moral environment in which children are growing up; and recommend ways of improving it.
- Size up present services for children and youth; map the direction in which services should develop; point up ways in which the number of qualified workers can be increased and the skills of these workers sharpened.
- Examine into the ways people are now working together for children; and develop ideas for more effective teamwork.
- Initiate steps for the achievement of the conference recommendations in the coming decade.

IN MEMORIAM

It is their tomorrow hangs over the earth of the living
And all that we wish for our friends: but existence is believing
We know for whom we mourn and who is grieving.

—W. H. AUDEN

C. Anderson Aldrich, M.D., October 6, 1949, Rochester, Minnesota. Pediatrician and director of the Rochester Child Health Project. Won 1948 Lasker Award for Mental Hygiene for work as "first integrator of pediatrics with preventive psychiatry" and training of physicians in the psychological aspects of medicine

Margaret C. Ball, 1949, Milton, New York

Mrs. Claire Buller, 1949, public health nurse, Riverside County Health Department, Riverside, California

Elizabeth C. Burgess, July 22, 1949, New York, New York. Professor emeritus of nursing education at Teachers College, Columbia University; president, from 1928-32, and board member, National League of Nursing Education; member of Committee on Grading of Nursing Schools. See PUBLIC HEALTH NURSING, September 1949, p. 517

Chapel S. Carter, May 13, 1949, Ansonia, Connecticut

Elizabeth B. Carter, August 23, 1948, Ansonia, Connecticut

Mrs. Ella T. Chalmers, 1949, Lahaina, Maui, T. H.

Margaret Croken, June 11, 1948, Springfield, Massachusetts

Emily Diman, May 12, 1949, Providence, Rhode Island

Mrs. Cleveland H. Dodge, May 18, 1949, Riverdale-on-Hudson, New York. A generous and interested friend of health and welfare programs, and the NOPHN through many years

Ann Forsyth, February 27, 1950, Philadelphia, Pennsylvania. Served as chief nurse in Veterans Administration, Philippine Islands

Mrs. Thelma Foster, November 1, 1949, killed in airplane collision. Nursing supervisor for Southeastern Territory of Metropolitan Life Insurance Company. Former staff nurse and supervisor of Kansas City, Missouri, VNA; director of nursing activities of Nashville-Davidson County Chapter, ARC

Mrs. Martha M. Geboo, October 15, 1949, Muskegon, Michigan. Supervisor of Muskegon VNA, 1920-1942

Antonia Gibson, October 12, 1949, Sumter, South Carolina. Only woman to win Outstanding Citizenship Award in 1944. Charter member and secretary from 1916-1920 of South Carolina SNA

Mrs. E. K. Hall, 1949, Hanover, New Hampshire

Bertha Hampton, December 2, 1949, Glens Falls, New York. First visiting nurse in Glens Falls

Janice Jones, 1949, Tulsa, Oklahoma

Katharine Keegan, February 9, 1950, New York, New York. Public health nurse in New York City Department of Health for 30 years

Eleanor Scott Lafferty, March 27, 1949, Chehalis, Washington. Former president of District 29, California SNA

Mrs. George M. Laughlin, Jr., 1949, Pittsburgh, Pennsylvania

Harriet Louise Lee, May 15, 1949, Hempstead, New York

John D. Long, M.D., September 18, 1949, Guayaquil, Ecuador. Former Public Health Service officer, noted for work against bubonic plague and development of sanitation programs in South American countries

Mrs. Winifred M. Mather, 1949, Montclair, New Jersey

Ella M. W. McCanna, January 31, 1950, Cranston, Rhode Island. Director of school nursing of the Cranston Health Division

Blanche Peterson McGinnis, March 22, 1949, Los Angeles, California. Pioneer in public health nursing and former supervisor of public health nursing of Los Angeles Health Department

Mrs. Bradford O. McIntire, March 3, 1948, Carlisle, Pennsylvania

Rose C. McKeon, April 1949, Miami Beach, Florida

Mrs. Gertrude C. Meade, January 23, 1950, Visalia, California. Served with California Home Missions Council, Agricultural Health and Medical Association, and Tulare County California Health Department

Nannie P. Montgomery, 1949, public health nurse, Amador County schools, Jackson, California

Mae E. Murphy, April 13, 1949, San Diego, California. Member of Board of Directors of District 8 of the California SNA

Virginia Neibel, 1949, public health nurse, Oakland public schools, Oakland, California

Rita A. Nielsen, November 15, 1949, Winfield, Illinois

Clara B. Norbeck, May 31, 1949, Rockford, Illinois

Katherine E. Payne, 1949, Albany, New York. Education consultant, Division of Public Health Nursing, New York State Department of Health

Sara B. Place, June 24, 1949, Chicago, Illinois. Retired in 1947 after 30 years of service as superintendent of the Infant Welfare Society of Chicago. In 1925, she added mental hygiene to the Society's program and made that agency the first public health nursing service in the United States to include mental hygiene as an integral part of its program

Mrs. Donald A. Rogers, November 27, 1948, Moorestown, New Jersey. Vice-president of the Moorestown VNS

Mrs. Rollin S. Saltus, January 8, 1949, Mount Kisco, New York

Mrs. Elizabeth R. Taylor, November 24, 1949, Detroit, Michigan

Dr. V. C. Thorne, January 18, 1948, New York, New York

Mrs. Ferdinand Thun, 1949, Wyomissing, Pennsylvania

Bertha Tillotson, August 1, 1949, Middletown, Delaware. Served on staffs of St. Andrew's Episcopal

School, William and Mary College, U. S. Signal Corps during World War II, and cited after World War I for work of raising funds for American Red Cross

L. M. B. Underhill, March 21, 1949, Woodsville, New Hampshire

Mrs. Leonard D. Verdier, June 15, 1948, Grand Rapids, Michigan

Frederick C. Walcott, 1949, Norfolk, Connecticut

E. Allene Warren, August 26, 1948, Newton, New Jersey

Alvina Wellensiek, 1949, public health nurse, Sacramento City Unified School District, Sacramento, California

Harriet L. Wieand, spring 1949, Trenton, New Jersey. The state's first school nurse

A MESSAGE ABOUT POLIO

Health departments, doctors, hospitals and chapters of the National Foundation for Infantile Paralysis have made plans for help and medical care if polio should come.

WHAT TO DO IF POLIO COMES YOUR WAY

Keep children with their own friends. Keep them away from people they have not been with right along, especially in close daily living. Many people have polio infection without showing signs of sickness. Without knowing it, they can pass the infection on to others.

Try not to get over-tired by work, hard play, or travel. If you already have the polio infection in your body, being very tired may bring on serious polio.

Keep from getting chilled. Don't bathe or swim too long in cold water. Take off wet clothes at once. Chilling can lessen your body's protection against polio.

Keep clean. Wash hands carefully before eating and always after using the toilet. Hands may carry polio infection into the body through the mouth. Also keep food clean and covered.

Watch for early signs of sickness. Polio starts in different ways—with headache, sore throat, upset stomach, sore muscles, or fever. Persons coming down with polio may also feel nervous, cross or dizzy. They may have trouble in swallowing or breathing. Often there is a stiff neck and back.

ACT QUICKLY—IT MAY LESSEN CRIPPLING

Call your doctor at once. Until he comes, keep the patient quiet and in bed, away from others. Don't let the patient know you are worried. Your doctor will tell you what to do. Usually polio patients are cared for in hospitals, but some with light attacks can be cared for at home.

Call your own chapter of the National Foundation for Infantile Paralysis if you need help. (Look for the number in the telephone book or call your health department for the address.) Chapters are made up of people in your own town or county, banded together to give help to polio patients. Polio is a very expensive disease to treat. *But no patient need go without care.* You pay what you can afford—your chapter pays the rest of the cost of care. This help includes payment of hospital bills, nurses and physical therapists, transportation to and from hospitals or clinics, treatment after the patient leaves the hospital, wheelchairs and braces when needed. This is not a loan. The American people make these services possible by giving to the March of Dimes.

Remember—there is no "quick cure" for polio and no way as yet to prevent it. With good care, most people get well, but some must have treatment for a long time.

The more you know about polio, the less you fear. More than half of all people who get the disease recover completely without any crippling.

IF POLIO COMES, ACT QUICKLY. CALL YOUR DOCTOR. DO WHAT HE SAYS. ASK FOR HELP IF YOU NEED IT. YOUR NATIONAL FOUNDATION CHAPTER IS STANDING BY TO AID YOU.

NEW BOOKS
AND OTHER PUBLICATIONS

THE NEUROSIS OF MAN

Trigant Burrow. New York, Harcourt, Brace and Company, 1949. 456 p. $7.50.

The nurse who is caring for a neurotic patient is a link between his dissociation and the normal life to which he must adjust himself if he is ever again to enter the world outside the hospital. This fact will make the book under review especially valuable to her. According to Dr. Burrow, "the behavior of man that is held to be normal. . . . is not normal; it is abnormal." Thirty years ago he was led to the realization that "there is as yet no stable or dependable norm of health within the domain of human relations."

To sense the meaning of this we might consider how helpless an internist would be if he had to diagnose and treat patients without having any objective tests or fixed standards of healthy structure and function. In the case of man's relations with his fellow men there is no objective norm by which to judge what healthy interrelations are. With the recognition of this condition Dr. Burrow was forced out of the mental clinic and into the socio-biological laboratory. He became more and more interested in the problem of establishing through experiment a norm of interrelational reactions that would be as consistent and universal as the norms generally accepted in other domains of medicine. Setting aside his psycho-analytic practice, and assembling a research group composed of normal and neurotic individuals—some medically trained, some lay students—he devoted the next thirty years to an intensive search for a biological standard of behavior.

The Neurosis of Man reports in an interesting and readable way the development of the investigation and its findings. It reveals the neurotic behavior of our patients as the symptom of a conflict between two opposing patterns of physiological tension—a conflict which is now common to the community and which renders it difficult for our patients to make healthy adaptations when they leave the hospital. It is the thesis of the book that since the cause of neurosis, both individual and social, is traceable to a disturbance in physiological tension the remedial measures for the condition must also be physiological.

The thoughtful nurse will find *The Neurosis of Man* a courageous effort to meet problems heretofore insoluble.

—CHARLES B. THOMPSON, M.D., *Director, Mental Hygiene Clinic, Bellevue Hospital, New York, New York.*

THE ART AND SCIENCE OF NUTRITION

By Estelle E. Hawley and Grace Garden. St. Louis, C. V. Mosby Company, 1949. 700 p. edition. $4.75.

In the new edition of the book the authors have incorporated many of the recent research findings in nutrition and diet therapy. The material is presented in the same simple orderly manner as in the previous editions.

Early chapters deal with the food constituents in terms of body needs, the sources of these nutrients, and their metabolism in the body. Following there is a comprehensive discussion of the recommended food allowances for individuals of varying ages and activities, and the planning of meals to insure adequacy of the family diet.

Part III brings the reader up to date on the current trends in diet therapy, including the new emphasis on protein metabolism, with the resulting tendency toward more protein in the therapeutic diet. With considerable attention being placed on the sodium content of diets in the treatment of hypertension, the authors have supplemented their interpretation of the low sodium diet by including in the appendix a detailed table on the sodium and potassium analyses of foods and water. Throughout the discussion of the various therapeutic diets emphasis is placed on planning the diet for the patient considering his food habits and meeting his individual needs for normal nutrition.

The suggested laboratory lessons on the choice, preparation, and serving of foods follow the teaching outlines formulated jointly by the National League of Nursing Education and the American Dietetic Association.

Although specifically a text for schools of nursing, this book would serve as an excellent reference for the public health nurse.

—M. Elizabeth Vaughn, *Nutrition Consultant, Visiting Nurse Association, Detroit, Michigan.*

MALE AND FEMALE

Margaret Mead. New York, William Morrow & Company, 1949. 477 p. $5.00.

Here is a book that has both attained a best-seller status and has earned for its author the honor of election to the post of Woman of Science for 1949. Most newspaper critics have reviewed "Male and Female" favorably: "worth a thousand of Dr. Kinsey's statistical studies," and "a vast turbulent book. . . too completely coherent for the incoherence of the average American mind." Professional colleagues have not been so kind.

Dr. Mead, Associate Curator of Ethnology, American Museum of Natural History, is probably America's best publicized anthropologist. She speaks with equal ease the jargon of psychiatry, nutrition, philosophy, and sociology. In this book she has used concepts from these fields more as window dressing than as tools for analysis. They will not trip up the reader, however, because Dr. Mead's contexts are clear enough.

Dr. Mead has made three contributions in this book. First, she brings to us a greater awareness of the way in which the differences and similarities in the bodies of human beings are the basis on which all our learnings about the sexes are built. Second, she draws on seven South Sea cultures which she has studied herself to show how each has attempted to develop a myth of work to bind men to women and children, to get the children fed and reared, and to settle the problems that arise whenever individual sex impulses must be disciplined into social forms. Finally, in a section rich in speculation and sparse in documentation, entitled "The Two Sexes in Contemporary America," Dr. Mead deals with childhood, courtship, and marriage in our own crazy-quilt society. She concludes this exploration with suggestions by which our civilization may make as full use of women's special gifts as we have of men's, promising that in so doing we will develop forms of civilization that will make fuller use of all human gifts.

Members of the medical and nursing professions will be surprised to discover that the infant feeding situation is a prototype of the infant's later sex relationship, a prototype not only in complementary design, but also in emotional tone, (p. 288) that mouth-breast and penis-vulva relations are intertwined, and that middle-class virtues are learned out of mother-child relations to the gastrointestinal tract, taking in, keeping, giving out, and yet maintaining impulsive masculinities (p. 316). Few, if any, of Dr. Mead's generalizations are more documentable than the above. Time may yet demonstrate that her ideas are more than novelties, that they are brilliant insights, momentary illuminations of what lies behind our society's drawn shades.

—Reuben Hill, *Ph.D., Research Professor in Family Life, Institute for Research in Social Science, and Professor of Sociology, the University of North Carolina, Chapel Hill, North Carolina.*

A DYNAMIC APPROACH TO ILLNESS

Frances Upham. New York, Family Service Association of America, 1949. 200 p. $3.00.

This book, while written primarily for social workers—as the title implies—will have great interest for public health nurses and others in the health field. Miss Upham from her broad experience tells of the emotional and economic problems which illness creates. She stresses the importance of team work on the part of all and challenges each to understand and treat the patient as an individual with his own particular personal and family problems. In the chapters on cancer, tuberculosis, venereal disease, and chronic illness she emphasizes the fact that while one finds certain anxieties in common no two people react in exactly the same way.

The organization of chapters 5-11 is essentially the same. Miss Upham discusses the extent of the problem, the medical aspects, social factors involved, and the essentials of an adequate program on national, state, and

local levels. As the author intended, the book is essentially a digest of the literature. Each source of material is carefully annotated, and the complete bibliography will enable one to pursue such aspects of the subject as one wishes.

The book is written with clarity and vitality, and will, in my opinion, be welcomed by the nursing profession as well as by social workers. As Eleanor Cockerill has so well pointed out, the actual use of the book is "dependent upon the capacity of each practitioner to incorporate these concepts and make them his own. . . . Miss Upham's simplicity of expression and direct handling of some very complex concepts should not lead the reader to the assumption that the application is simple." (Quotes are from Miss Cockerill's review in the Journal of Social Case Work, November 1949.)

—ECKKA GORDON, *Director of Social Service, Grace-New Haven Community Hospital.*

PUBLIC SCHOOL AUDIOMETRY

Mrs. Lorraine Anson Dahl. Dansville, Ill., The Interstate Press, 1949. 290 p. $3.00.

This book is the sincere attempt of an experienced, well-informed, and interested audiologist to amass, within the covers of one book, ALL the whys, wherefores, and hows of current school hearing tests.

The first two parts of the book are devoted to a documentation of existing literature on the otological, public health, and rationale of a hearing conservation program. Although no original material is included, a beginning student will find these sections helpful orientation on the subject.

A novice might gain some help from the over-simplified and repetitious detail in the last two sections, but in this reviewer's opinion would be confused by their length and lack of logical organization. For example, directions for retesting precede the instructions for giving the first test.

In general, the text rates a listing on a bibliography of hearing conservation materials, although it may not be starred for required reading.

—ELEANOR C. RONNEI, *Head, Educational Services, New York League for the Hard of Hearing.*

A BOY GROWS UP

Harry C. McKown. New York, McGraw-Hill Book Company, 1949. 333 p. 2nd edition. $2.40.

Public health nurses often feel more competent to advise parents concerning the problems of their adolescent daughters than concerning those of boys of the same age group. While this book is written for the teen age boy to read, it may be very helpful to certain nurses. For the nurse whose experience with growing boys has been limited, it will furnish a quick survey of the current problems boys are facing. In addition to such factual material she will welcome the guidance it gives her concerning her attitudes and the attitudes she might help parents develop toward the problems and toward the boys themselves.

The scope of the book is broad, including, desirably, even more attention to social, emotional, and mental growth and development than to the physical. Well chosen case studies make it easy reading. It is a book the nurse can safely recommend for school faculty use and for parents, as well as for the boys themselves. The bibliography is excellent.

—MARIE SWANSON, *R.N., School Nursing Consultant,* NOPHN, *1790 Broadway, New York 19, New York.*

FAMILIES UNDER STRESS

Reuben Hill. New York, Harper & Brothers, 1949. 443 p. $4.50.

In the preface the author points out that man's place in society has changed from making a living to buying a living. This makes for a greater interpersonal relationship and the modern family lives in a greater state of tension. This study is concerned with changes in the family picture and especially aimed at stress and crisis and their influence on the family.

Iowa families drawn from a random sample of 100 local selective service boards make the basis of the group. One hundred thirty-five cases were finally used and carried to the end of the study. The social status, education, income, number of children and their position, the dominance of husband and wife, and many other factors are evaluated to cover the entire family life setting. The author by use of charts and graphs shows how crisis, disorganization, recovery, and reorganizations in these

families brought about by war separation and peace reunion occurred and what factors played the most important part in the overall picture.

In the closing chapters he points out two main factors to be considered. Adequate income is not enough to avoid or influence the stress very much and there is obviously not enough preparation for marriage and family life. In this matter of preparation for marriage he feels much is lacking in most families. He feels there should be some local and national policy to help in these areas.

The book is a challenge to the present pattern of living and tries to outline briefly some direction for the future. It is recommended for anyone who has to deal with the family. Sociologists, social psychologists, public health nurses, social workers, and psychiatrists should find it revealing and informative.

—William H. Kelly, *M.D., Director-Psychiatrist, Memorial Guidance Clinic, Richmond 22, Virginia*

CHILD CARE

New York City's Baby Book. 2nd printing, 1949. 136 p.

Free copies may be obtained by writing to the New York City Department of Health, 125 Worth Street, New York, New York.

CHILD WELFARE

The Backward Child. Mental Hygiene Division, Department of National Health and Welfare, Ottawa, Canada, 1949. 60 p. 25c.

Write to Supervisor of Government Publications, Department of Public Printing and Stationery, Ottawa, for copies.

Essentials of Adoption Law and Procedure. Children's Bureau Publication No. 331. Government Printing Office, Washington, D.C. 1949. 27 p.

GENERAL

Audiology, the Science of Hearing. Norton Canfield. Springfield, Illinois, Charles C. Thomas. 1949. 45 p. $1.75.

A monograph by the pioneer in this field, which includes all the separate professional abilities contributing to this rapidly progressing specialty. There are chapters on the fenestration operation, the role of the psychiatrist, speech audiometry, speech therapists, et cetera.

GERIATRICS

Never Too Old. New York State Joint Legislative Committee on Problems of the Aging. 1949. 216 p. Write to State Senator Thomas C. Desmond, 94 Broadway, Newburgh, for free copy.

HOUSING

The Local Community Job under the Housing Act of 1949. Housing & Home Finance Agency, Washington 25, D.C. 1949. 26 p. A bulletin for leaders of local community groups.

INDUSTRIAL NURSING

A Handbook for Industrial Nurses. Marion M. West. Edward Arnold & Co., London. 2nd ed. 1949. 264 p. 9 shillings.

Industrial Microbiology. Samuel Cate Prescott and Cecil Gordon Dunn. McGraw-Hill Book Company, New York. 2nd edition. 1949. 923 p. $8.50.

MARRIAGE COUNSELING

The Engaged Couple Has a Right to Know. By Abner I. Weisman. Renbayle House, 1165 Broadway, New York 1, New York. 1949. 256 p. $3.00.

MENTAL HYGIENE

Looking Ahead to Marriage. Clifford R. Adams. Science Research Associates, Inc., Chicago 4. 1949. 48 p. 60c. One of the series in the Life Adjustment Booklets of the publishers. Written for young people between the ages of 16-22 and for those working with the age group, attractive illustrations, interesting questionnaire, and simple discussions of subject matter.

NURSING

Textbook of Practical Nursing. By Kathryn Osmond Brownell. W. B. Saunders Company, Philadelphia. 3rd edition. 1949. 465 p. $3.75.

FROM NOPHN HEADQUARTERS

COMMITTEE ON ALLOCATION OF FUNCTIONS AND PROGRAM

In accepting the final recommendations of the Committee on the Structure of the National Nursing Organizations, the NOPHN Board of Directors voted to review the organization's present programs and functions before the Biennial Convention in order to see where these could logically be placed in any new organizational structure.

With this in mind, the NOPHN set up the Committee on Allocation of Functions and Program. Ruth Freeman, vice-president of the NOPHN, is chairman. A two-day meeting was held in March and another is scheduled for April.

The NOPHN president, Ruth W. Hubbard, has invited representatives of the other five national organizations, which have been reviewing their functions and programs also, to meet with NOPHN representatives to pool their thinking before the San Francisco meeting. Miss Hubbard hopes that through these explorations a preliminary report, at least, will be ready for discussion by the board and the membership during the Biennial.

COUNCIL OF BRANCHES MEETING

The 19th annual meeting of the Council of Branches was held March 24 and 25, 1950 in Chicago at the Hotel Stevens.

Four general members were present: Mrs. Merritt W. Riggs, Iowa; Mrs. Arthur Evans, Maryland; Mrs. Robert Angell, Michigan, and Mrs. Robert Ely, Wisconsin. The following presidents of SOPHN's attended: Mrs. Marjorie Gamble, Arkansas; Mrs. A. Stanley Hardman, California; Mrs. Lucy Dippert, Iowa; Alexandra Matheson, Kentucky; Marion Souza, Louisiana; Alice Sundberg, Maryland; Helen Law, Minnesota; Alice Jensen, Nebraska; Eleanor Duffy, New Jersey; Mary Beam, Pennsylvania; Catherine Sullivan, Rhode Island; Gertrude Mulaney, Wisconsin.

The chairman of the council, Winifred Fisher, presided at the business meetings and at two of the discussion sessions; Mrs. Merritt Riggs at the third discussion session. Marion Souza is chairman of an Evaluation Committee which will present recommendations concerning future meetings.

The reports presented by the individual states, as well as the general discussions, and the brief historical summary presented by Miss Fillmore all emphasized the working together of citizens and nurses, as groups and as individuals for the improvement of community health. Miss Hubbard, president of NOPHN, attended the Saturday session and led the discussion on "Trends in Nursing Services and Nursing Education." An account of the unusually interesting discussions will appear in a later issue.

Mrs. Robert Ely, of Wisconsin, was elected chairman of the council for the coming year, and Alice Sundberg, of Maryland, vice-chairman.

ELIGIBILITY COMMITTEE

The Eligibility Committee which studies and makes recommendations on agencies' applications for NOPHN membership met in New York on March 3rd. The chairman, Mary Harrigan, conducted the meeting. The following members were also present: Catherine L. Austin, Edna Moorhouse, Mary C. Mulvany, Mrs. Helen Watkins, Harriet F. Young, Ruth Fisher, and Dorothy Rusby, secretary. Fifteen agencies were granted membership. For the complete list, see the spring issue of *Phn*.

PSYCHIATRIC NURSING PROJECT

Under a continued grant-in-aid from the United States Public Health Service, the NLNE in cooperation with the NOPHN is making a study to assist with the formulation of a statement of desirable qualifications for all mental hygiene and psychiatric nursing personnel.

The first step in this study was to mail, through the directors of psychiatric and mental hygiene facilities in the United States and territories, a one-page questionnaire to all nurses (approximately 10,000) in the field of psychiatry at the present time. This will aid in the determination of the qualifications of these nurses as to academic and clinical experience. If you have a questionnaire and have not yet returned it, please mail it today.

JONAS MATERIALS

A new four-page leaflet, *Polio Nursing*, has just been completed. This was prepared by JONAS in cooperation with NFIP. In a few words, the leaflet presents suggestions for a community plan should an epidemic occur. Copies may be secured free of charge from JONAS, 1790 Broadway, New York, 19.

The JONAS staff has also prepared two suggested outlines which will help instructors in teaching the nursing care of the poliomyelitis patient. These outlines are set up for a five-day course. Order directly from JONAS. No charge.

RECORDS COLLECTION

On March 9 and 10, a meeting of the Subcommittee to Gather and Analyze Records for the 1950 loan collection was held at the IVNA in Baltimore. Those attending were Lucille A. Wallis from the Maryland State Department of Health, chairman of the subcommittee; Dorothea McKee of the VNS of Philadelphia; Ethel Turner, superintendent of the Baltimore IVNA; and Mrs. Mary Elizabeth Bauhan, statistician of the NOPHN and secretary of the NOPHN Records Committee.

The collection will include generalized family records, generalized individual records with all services integrated, specialized family case records, and specialized individual records according to the type of service given.

The number of generalized records will make this collection of special interest to agencies who are considering this type of record keeping.

The collection will be on display at the Biennial Nursing Convention in San Francisco, daily from 1:00-3:00 P.M., in the NOPHN Records Room.

NOPHN FIELD SCHEDULE—APRIL

Staff Member	*Place of Visit*
M. Olwen Davies	Boston, Mass. Ann Arbor, Mich.
Marion Kerr	Charleston, W. Va. Fairmont, W. Va. Bethlehem, Pa.
Lois Olmstead	Baton Rouge, La. Alexandria, La.
Dorothy Rusby	Winston Salem, N. C. Roanoke, Va. Lewisburg and Nashville, Tenn
Elizabeth C. Stobo	Roanoke, Va. Lewisburg and Nashville, Tenn
Jean South	Roanoke, Va., Miami, Fla. Washington, D.C.
Louise M. Suchomel	Boston, Mass. Merced and Atwater, Cal.
Marie Swanson	Boston, Mass.

ABOUT PEOPLE YOU KNOW

G. Elizabeth Reynolds is retiring as director of the Chicopee Community Nursing Association. . . . *Wilma L. Schleicher* will leave her position with the El Paso County (Colorado) Department of Health to become public health nurse in the Juneau Health Center in Alaska. . . . As director of nursing services of the Chatham-Savannah Health Council in Georgia, *Patricia Cannon* replaces *Mary McNally* who has been acting director. . . . *Mrs. Augusta B. King* has been appointed executive secretary of The Bronx Tuberculosis and Health Committee. She succeeds *Gladys A. Adams*, who recently retired after 20 years in this post. . . . *Doris Marie Jugenson* will replace *Margaret Torr* as consultant nurse on the staff of the Division of Public Health Nursing of the Indiana State Board of Health. . . . *Elizabeth Holley* is director of the VNA in Daytona Beach, Florida.

NEWS AND VIEWS

THE NATIONAL HEALTH COUNCIL

The 30th annual meeting of the National Health Council was held in New York on March 24th. At the board meeting the following were elected: president, Dr. Ernest L. Stebbins; vice-president, Mrs. Oswald B. Lord; treasurer, Mr. Philip R. Mather; assistant treasurer, Mr. Herbert I. Wood; and the secretary, Dr. James F. Perkins, was re-elected.

Dr. Willard C. Rappleye, dean of the College of Physicians and Surgeons, Columbia University, was the luncheon speaker. His topic was: Personnel—The Key To Effective Health Programs. Dr. Rappleye said there was now one physician to every 695 persons in the United States and that we did not lack doctors in numbers. The problem is one of distribution. The need is for better prepared doctors and for keeping them abreast of new knowledge and methods. He agreed there are shortages within some of the specialties in medicine, such as, psychiatry, pathology, industrial medicine, radiology.

Discussing trends Dr. Rappleye said (1) in the future an increasing proportion of the population will be in the older groups and a larger part of the health needs will be associated with the disabilities and illnesses of middle and old age. This presents a major crisis to the hospitals which the emphasis upon ambulatory care and home care of patients will go far in relieving (2) the American public is convinced of the value of adequate health services and is determined that the benefits of modern science will be made available to all. It is up to the experts to propose ways and means by which sound progressive plans can be formulated. A course must be plotted between those who urge complete governmental control and management and those who are equally strong in defending the status quo (3) shortages of nurses and dentists do exist. Properly trained and supervised auxiliary assistants could free the professional workers in these fields for work requiring a high degree of independent judgment and competence.

In the afternoon a symposium on Early Case-Finding was held. The discussants were: Dr. Brewster S. Miller, American Cancer Society; Dr. Howard F. Root, American Diabetes Association; Dr. David D. Rutstein, American Health Association; Dr. Franklin M. Foote, National Society for the Prevention of Blindness; Dr. Floyd M. Feldmann, National Tuberculosis Association; and Dr. A. L. Chapman, U. S. Public Health Service. All discussed the common denominator in case-finding. Dr. Chapman reported that "multiple screening is designed to borrow the advantages of categorical screening programs and to combine them into a single operation with a resultant increase in efficiency and a decrease in cost." He said in pilot programs which have been carried out in several communities, the public has shown its approval of mass case-finding by flocking to the examinations. The list of potential tests is almost limitless. It doesn't seem unreasonable that in the near future there may be a single skin test for allergies; a practical liver function test; serological tests for incipient arteriosclerosis, and a blood test for cancer.

Before us lies a period of case-finding achievements that can be measured only by the imagination of man.

SHORT COURSES IN POLIO

The NFIP has announced a list of schools that are scheduling short, postgraduate courses in the treatment of poliomyelitis patients. Physicians and nurses who require financial assistance to attend the courses should refer to the local chapters of the NFIP, and physical and occupational therapists directly to the National Foundation. Enrollment must be

arranged directly with the training center.

CHILDREN'S MEDICAL CENTER, BOSTON, MASSACHUSETTS

Dr. William T. Green, director. Courses for nurses, one month beginning July 3 and October 2; for physical therapists, six weeks beginning July 3.

CITY HOSPITAL, CLEVELAND, OHIO

Courses for nurses, two weeks; for physical therapists, two weeks, scheduled dates not yet determined for 1950.

D. T. WATSON SCHOOL OF PHYSICAL THERAPY, LEETSDALE, PENNSYLVANIA

Dr. Jessie Wright, director. Dates are specially arranged, depending upon individual need, for 1-3 week courses for physicians, nurses, and physical therapists. Emphasis on when to prescribe the respirator and when the rocking bed, and care of and procedures for patient in respirator and rocking bed.

GEORGIA WARM SPRINGS FOUNDATION, WARM SPRINGS, GEORGIA

For physical and occupational therapists, 3 months beginning the first Monday in January, April, July, and October. A limited number may stay 6 months if requested.

ORTHOPEDIC HOSPITAL, LOS ANGELES, CALIFORNIA

Nurses and physical therapists, May 15-20, October 2-7 (tentative dates).

STANFORD UNIVERSITY, DIVISION OF PHYSICAL THERAPY, PALO ALTO, CALIFORNIA

Lucille Daniels, director. One course for physical therapists is usually scheduled each summer, though date for 1950 has not yet been determined. Special programs can be arranged for one or more quarters throughout the year.

UNIVERSITY OF COLORADO MEDICAL CENTER, DENVER, COLORADO

Dr. Winona G. Campbell, director. Tentative date for 1950 for nurses, occupational and physical therapists, June 19-July 7.

CIVILIAN NURSES ON GUAM

Civilian nurses will be appointed to positions of superintendent of Guam Memorial Hospital, and supervisors at the School of Nursing to replace naval personnel when the Department of Interior assumes administrative responsibility for the Island of Guam, beginning July 1.

The Guam Memorial Hospital, now housed in temporary quonset structures, has about 275 beds, including a tuberculosis ward and a staff of ten medical officers, serving primarily the Guamanian population.

The nursing positions will carry a salary of $3,875 per annum. Transportation is paid for employees and their dependents by the Government of Guam. Furnished government quarters are available at nominal rental.

Further inquiries about these nursing opportunities should be addressed directly to Carlton Skinner, Governor of Guam, Administration Building, Agana, Guam, M. I.

RECRUITMENT PROGRAM

To meet the increasing demand for experienced health personnel for overseas missions which have been authorized by Congress, the Division of International Health, USPHS, plans to recruit nurses for overseas assignments. These assignments which will be in the higher grades will involve employment either by the Public Health Service or by WHO. Recruitment will be limited to highly qualified personnel possessing expert knowledge in their technical specialties.

Members of technical health missions can assist foreign governments in establishing public health training, initiate health demonstrations, supervise specific projects, and serve in an advisory capacity to foreign government officials on health matters.

Qualified health personnel may obtain application forms and further details by writing to the Chief, Division of International Health, Public Health Service, Federal Security Agency, Washington 25, D. C.

IRAN ASSIGNMENT

Three public health officers have been detailed to Teheran, Iran, to assist the Iranian government in developing a strong public health service. The American team, which is being dispatched in response to a request for assistance from the Iranian government, will aid in establishing public health training, initiate health demonstrations, and serve in an advisory capacity to the Iranian government.

Dr. Emil E. Palmquist of Seattle, Washington, will serve as medical officer in charge of the project. Other members of the team are Frederick F. Aldridge, of Seattle, sanitary engineer, and Esther M. Finley of Charleston, West Virginia, public health nurse.

WATER POLLUTION REPORTS

To supervise the publication of comprehensive reports of water pollution conditions in this country, the USPHS has created a new unit. Established as part of the Division of Water Pollution Control, the new unit is known as the Reports Analysis and Statistics Branch.

AMERICAN MUSEUM OF HEALTH

The American Museum of Health, located in Gillet Hall, on the Bronx campus of Hunter College, New York, opened its doors to the public in April. The nucleus of the exhibit is the models—the Transparent Man, Big Ear, Voice Organ, the Blood System, et cetera, which were displayed at the Medical and Public Health Building at the World's Fair in 1938-39.

The largest of its kind in the world, the museum is sponsored by the New York Academy of Medicine, Columbia and Harvard Schools of Public Health, Johns Hopkins University and others. Admission is free.

WHAT'S NEW IN THE VA

Public health nurses appointed to posts with the Veterans Administration during 1949 include:

Iva Torrens, chief, Community Nursing Division, central office. *Alice C. Mooney,* transferred from former branch office in Boston to be assistant chief in the Community Nursing Division.

Chiefs in VA regional office clinics and VA office clinics include:

Gertrude Beattie, Rochester, New York; *Bridget Elizabeth Burns,* Pittsburgh, Pennsylvania; *Mrs. Therese Kerze Cheyovich,* Los Angeles, California; *Margaret Celeste Cody,* Kansas City, Missouri; *Florence R. Cohen,* Dallas, Texas; *Mrs. Lenora M. Corbett,* El Paso, Texas; *Beatrice Hill Ditto,* Detroit, Michigan; *Mrs. Mary French,* Denver, Colorado; *Elizabeth C. Gauscheman,* Huntington, West Virginia; *Mary E. Higgins,* Peoria, Illinois; *Gwendolyn Roberta Hussey,* Philadelphia, Pennsylvania.

Sophia Alice Jarc, Cleveland, Ohio; *Laura J. Jones,* Albuquerque, New Mexico; *Mrs. Regina T. Kelly,* Wilkes-Barre, Pennsylvania; *Helen Louise Leiser,* Salt Lake City, Utah; *Virginia Marie Loupret,* Lowell, Massachusetts; *Martina C. Lynch,* Providence, Rhode Island; *Mrs. Elizabeth Leger Martin,* Buffalo, New York; *Frances Louise Parish,* Louisville, Kentucky; *Mary E. Rase,* San Antonio, Texas; *Matilda Rudnick,* Bridgeport, Connecticut; *Mrs. Beatrice C. Stoegerer,* Washington, D. C.; *Martha A. Tempel,* Cheyenne, Wyoming; *Irene McMullan,* St. Louis, Missouri.

Public health nurses who were appointed or transferred during 1949 to clinics in VA regional offices or offices include:

Mrs. Ruth Ferber Blake, Boston, Massachusetts; *Margaret J. Cummings,* Washington, D. C.; *Elizabeth Curtis,* transferred from Portland, Oregon, to Los Angeles, California; *Mrs. Dorothea C. Gilligan,* Chicago, Illinois; *Mrs. Frances Martin Hoover,* Chicago, Illinois; *M. Evelyn Houff,* Washington, D. C.; *Gladys E. Johnson,* San Antonio, Texas; *Catherine Marie Joyce,* Boston, Massachusetts; *Mary Josephine Kislitzin,* San Francisco, California; *Inga Maria Koski,* Hartford, Connecticut; *Lillian Beatrice Kumli,* Washington, D. C.; *Lorraine Loesel,* Cleveland, Ohio; *Anna Dolores Mitch,* Syracuse, New York; *Donna Jean Olson,* Minneapolis, Minnesota; *Muriel K. Olson,* Minneapolis, Minnesota; *Eunice Pace,* Jackson, Mississippi.

Mrs. Evelyn V. Puesser, St. Louis, Missouri; *Merilys E. Porter,* Washington, D. C.; *Sarah W. Rogers,* Richmond, Virginia; *Marian Schisa,* Syracuse, New York; *Mrs. Ruth Harris Smith,* transferred from Oakland, California, to Seattle, Washington; *Helen Margaret Thomae,* Boston, Massachusetts.

Mr. Remi Alicide Trudeau, Boston, Massachusetts; *Pernell Ione Walstead,* Minneapolis, Minnesota; *Mrs. Irene M. Wettlaufer,* Buffalo, New York; *Winifred E. Dickerman,* Buffalo, New York; *Mrs. Mildred Fay Foster,* Milwaukee, Wisconsin.

New appointments in 1950 are:

Gladys Gallien, VA regional office in New Orleans; *Eloise M. Odegard,* regional office in San Francisco; *Emma Rittinger,* regional office in Huntington, West Virginia.

● The 27th annual conference of the American Physical Therapy Association will be held at the Hotel Statler, Cleveland, Ohio, June 26-30.

● "The Nurse in the School Health Program," a five-day workshop, will be held at West Virginia University, July 10-15. Mary Ellen Chayer, professor of nursing education, Teachers College, Columbia University, will be consultant, and nursing consultants from the Children's Bureau and USPHS will act as group leaders. For information write to Leada L. Neininger, Bureau of Public Health Nursing, West Virginia State Department of Health, Charleston 5, West Virginia.

● The Indian Service is planning a session of in-service training for public health nurses and teachers to be held at the Chemawa Indian School, Salem, Oregon, July 17-28. One week will be devoted to intensive work in tuberculosis with assistance from the Public Health Service.

Our Readers Say . . .

ANOTHER TRIBUTE TO THE PUBLIC HEALTH NURSE

With the greatest interest I have just read "My VNA Experience," by Joan McDermott, R.N., in the December issue of your journal. It has occurred to me that possibly an account of my own recent (and first) experience with the VNA might be useful, showing as it does the demands which may be made on the nurse's understanding and judgment, beyond the requirements of duty.

Anyone who has never been both a hospital patient and a home patient can have but little notion of the difference in situation from the point of view of the patient himself. Although I had been a patient in a number of hospitals at various times, I know that I had had no idea of the additional problems—or types of problems—faced by the home patient, until my experience following a recent accident.

My injury was a fractured foot, but my worst problem was the state of my mind and nerves. Even after I had been brought back to Wausau, Wisconsin, there persisted a feeling of unreasoning terror, of not being safe anywhere, and of being frantically afraid of everything. I was having nightmares, nervous upsets, and panic whenever I had to make any effort at all. No one was more aware of the abnormality of such a condition than I, but my psychological state was such that I simply couldn't pull myself together.

Even in a hospital, where one has help all around him and at least the routine services to depend upon, a patient feels a certain amount of worry and anxiety. But here at home, things were worse, for in addition to having pain and discomfort, I was inescapably in the midst of other problems. Unfortunately, it was the Christmas season, and the people with whom I stay had planned to be away for two weeks. This had previously seemed of little moment—particularly since I had also expected to be away. Of course, I couldn't expect others to change their plans at the last minute. But, on the other hand, now that I couldn't get up or down the stairs without help, and couldn't even reach the telephone in case of emergency, I couldn't be left without some contact with the outside world. I have lived in Wausau only a year, and all the people I know were either out of town or too busy with their own affairs to look after me. I might have used the Employment Service, but I didn't feel that I could take a stranger into the house, since I couldn't be responsible to the owners for the house and its contents. What was I to do?

Finally, one of my friends thought of the Visiting Nurse Service, and suggested that, to have a nurse come in once a day would at least assure me of a wait of not more than twenty-four hours if "anything happened."

But, although this seemed to promise a solution of some of the outer problems, it also presented a new problem. I rather dreaded having a strange nurse come in to see me. I had in the past had one or two experiences with persons who did not realize the psychological effect which the nurse's personality and attitude have on the patient. Since a patient's attention is temporarily directed forcibly toward himself and his condition, he feels defenseless and abnormally sensitive—"insecure" to the highest degree; and he therefore takes both kindness and unkindness more personally than at normal times. Even a completely well person cannot thrive without kindness and encouragement, and a patient still less. True enough, Nature does the healing; but encouragement steps on the self-starter to get her going, and then provides the fuel to keep her on her way. I know that, to me, certainly, medicine had always seemed like so much chalk-and-water; but a "human" and kindly nurse had not only made me want to get well but had made me feel and believe that I could get well rapidly. In the situation in which I found myself, then, it was obvious that, if I were to come through in safety and regain my balance nervously, I had to have a nurse who would understand this principle.

Fortunately, the Wausau VNA representatives did understand it. Realizing my condition, they were kind and very patient. Punctual in coming at the appointed times, they built up an assurance of their dependability. Gradually my sense of isolation and of having been abandoned (which had developed in spite of my knowledge to the contrary) began to disappear. My own self-control and my normal attitudes began to reassert themselves.

Although the nervous upsets persisted, reappearing at night for several weeks, I was able to get through that critical two-week period and to go back to my classes afterward. Now, five weeks later, I have begun to feel completely readjusted and almost as if nothing had happened. I am convinced, however, that this would not be true if the Wausau visiting nurses had not given me the *type of help* that they did.

LOUISE W. HANLEY, *Instructor in English*
University of Wisconsin